STATE OF DELAWARE

2010-2014 COMPREHENSIVE HIV PREVENTION PLAN AND STATEWIDE COORDINATED STATEMENT OF NEED

SEPTEMBER 2009

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

DELAWARE HIV CONSORTIUM

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INTRODUCTION

In the belief that local communities make the best decisions about the implementation of HIV prevention activities in their own neighborhoods, the Centers for Disease Control (CDC) requires states to form Community Planning Groups to produce Comprehensive HIV Prevention Plans that inform the content of the annual HIV prevention grant application. As Health Resource Services Administration (HRSA) requires a similar process for Ryan White applications and as prevention and treatment programs are most effective when coordinated with one another, Delaware integrated the HIV Prevention Committee and the Treatment Committee into the Integrated HIV Planning Council (Planning Council). The merger reduced duplication of effort, increased collaboration, and improved continuity of care.

The next logical evolution of the process was to integrate the HIV Prevention Plan and Ryan White Coordinated Statewide Statement of Need into a single document: The *2010-2014 Comprehensive HIV Prevention and Treatment Plan* (the Comprehensive Plan or Plan). The Comprehensive Plan is divided into eight sections:

THE 2010-2014 COMPREHENSIVE PLAN PROCESS

The Comprehensive Plan is the product of collaboration among Delaware partners united in the fight against HIV/AIDS: Planning Council members, Division of Public Health (DPH), other state agencies, service providers, persons living with HIV/AIDS (PLWHA), and committed community members. The Planning Council coordinated the Plan work, which began in 2005. Three work groups developed a series of assessments that examined the disease from the perspective of local agencies, providers and PLWHA, and in terms of prevention and treatment needs. The Planning Council also continuously monitored primary HIV/AIDS statistical data gathered by DPH. (The annual Delaware HIV/AIDS Surveillance Report is included as part of this document.)

The deadline for the completion of the Comprehensive Plan was summer 2009; but HRSA required that the *treatment* portion of the Plan [the Statewide Coordinated Statement of Need (SCSN or Treatment Plan)] be submitted by January 5, 2009. A Preliminary SCSN was drafted, reviewed by the Planning Council, and submitted. The draft SCSN, updated and reordered for logical integration, is incorporated into this document.

In completing the *prevention* part of the Comprehensive Plan, DPH and the Planning Council were privileged to be able to build on the solid work done to create the earlier plan completed in 2005. To determine the continued validity of the previous plan's findings and recommendations, the Planning Council examined them in terms of current statistical data, emerging trends, and results of assessments conducted by the Planning Council between 2005 and 2009.

PREVENTION FINDINGS

Identified trends with impact on program development include the following:

- A shifting in ordinance of Delaware's risk populations from IDU (42%), MSM (30%), and HET (16%) to HET (36%), MSM (27%), and IDU (27%).
- A sharp rise in newly diagnosed infections among African American females in 2008.
- A shift of incidence from a small number of relatively high-incidence areas to a larger number of relatively low-incidence areas.

The shift in ordinance among the priority populations by percentage of all cases is significant, but it is difficult to definitively establish causality for the change. All of the populations mentioned have been priority populations in Delaware for more than a decade and the shift has occurred during a period of reduction in the overall incident rate. It seems likely that the change in precedence has occurred as a natural progression of the epidemic through at-risk populations in the order in which they entered the epidemic: 1) the populations appearing earlier in the epidemic (IDU and MSM) having achieved a level of 'saturation' in the population members most at-risk resulting in a decrease in incidence—essentially through a process of attrition, and 2) populations appearing in the epidemic later (heterosexuals and HET partners of IDU) are still 'pre-saturation' and are still increasing in incidence. As mentioned in the Treatment Findings below, it is likely that these groups will achieve equilibrium, relative to prevalence, in two to three years.

The same is true of the growing equality between male and female heterosexual/IDU incidence in Delaware. Men appeared in greater numbers earlier in the epidemic (infected through IDU and MSM) and women appeared in greater numbers as the epidemic progressed (infected through sexual contact with male IDU and MSM). As the incidence among male IDU populations and MSM populations achieved zenith and decreased, the prevalence of infected men among women's sexual and needle sharing partners nonetheless increased (in part due to a fantastically successful treatment program)–preceding and predicting a rise of incidence among at-risk women.

Several additional conditions, developing over the last five to eight years, must be given consideration in order to have a full appreciation of the epidemic in Delaware today. From 2004 through 2008:

1. The incidence rate has diminished from 223 to roughly 172 (a reduction in incidence of roughly 23%).
2. The zip code with the highest incidence cases in each year 2004-2008 had only 34, 26, 23, 23, and 22 cases, respectively.
3. 71% (*over 2/3*) of all new cases have occurred in zip codes with 20 or fewer cases per year.
4. 32% (*1/3*) of incidence occurs in zip codes with five or fewer cases per year.

Simply stated, while the populations most at risk have not radically changed (though have changed order of precedence), the geographic dispersement of cases has significantly changed to reflect a greater percentage of incidence cases in smaller concentration within an increased number of rural and suburban areas throughout the state. Continued reliance on describing Delaware's epidemic by zip code is no longer sufficient to properly facilitate planning or targeting of services. This is increasingly evident as programs are successful in reducing overall incidence, and many zip codes may have very few incidence cases in coming years. A finer method of describing and addressing infection networks must be implemented.

EXECUTIVE SUMMARY

The evolution of the HIV prevention paradigm in Delaware that is most likely to contribute to continued success in reducing annual HIV incidence is an approach that:

- Emphasizes mass/environmental interventions to increase the likelihood that infected individuals will learn of their HIV status by recruiting individuals to voluntary HIV screening services and making HIV screening a routine part of medical care.
- Emphasizes investigation and disruption of defined infection networks through quick and thorough case-level data collection on index clients, partner elicitation, partner notification and infection network mapping.
- Emphasizes individual, on-going, low-intensity risk reduction counseling and partner services for all HIV infected individuals not accessing more intensive CRCS.
- Emphasizes institutionalization of prevention education and screening messages whenever possible.
- Emphasizes use and coordination of CBO-based programs in venues where institutionalization of prevention services is not possible; where audiences for targeted programs are defined with detail; where disruption of specific transmission networks or environments is possible; and where cost-effective.
- Emphasizes consolidation of services and elimination of duplication of services/programs in order to maximize utilization of service capacity.

Listed below are the prioritized populations and recommended interventions to be implemented from 2010 through 2014:

2010-2014 Comprehensive Plan Prioritized Populations and Interventions

1. **HIV Infected Individuals**
    a. Partner Services
    b. Comprehensive Risk Counseling Services (CRCS)
    c. Health Education/Risk Reduction (HE/RR): Low-intensity, on-going risk-reduction counseling services for those not accessing CRCS
    d. Mapping and disruption of transmission networks through intensive cases-study data collection and analysis and resulting implementation of ad-hoc, custom intervention needed to address specific network conditions
    e. Location of those not known to be in care and reconnection to treatment/case management as needed (in cooperation with Ryan White and HIV surveillance)

2. **Heterosexuals of all races, with emphasis on African American in the Wilmington/NCC area and emphasis on women that are pregnant or considering pregnancy**.
    a. Social marketing/mass media recruitment to HIV screening services
    b. Outreach recruitment to HIV screening and distribution of risk-reduction supplies
    c. Rapid HIV Screening/Referral Services
    d. HE/RR

3. **Injected Drug Users**
    a. Outreach recruitment to HIV screening and distribution of risk-reduction supplies.
    b. Rapid HIV Screening/Referral Services
    c. Needle Exchange (*not federally funded*)
    d. Multi-session Group Level Intervention/Individual Level Intervention (GLI/ILI) in residential treatment sessions

4. **Men that have Sex with Men (MSM), with special emphasis on African American and those frequenting the resort areas of Delaware.**
    a. Social marketing/mass media recruitment to HIV screening services.
    b. Outreach recruitment to HIV screening & distribution of risk-reduction supplies.
    c. Rapid HIV Screening/Referral Services.
    d. HE/RR

5. **Youth in secondary school, college/university and correctional settings.**
    a. Institutionalization of HE/RR and HIV screening services in education and detention settings
    b. Social marketing/mass media recruitment to HIV screening services
    c. Rapid HIV Screening/Referral Services

TREATMENT FINDINGS

Effective HIV/AIDS treatment plays a critical role in the fight against HIV/AIDS. It both improves the lives of those with the disease and contributes to prevention among those without it. The treatment portion of the Comprehensive Plan addresses services provided through Ryan White funding, as well as other federal and local dollars, outlining the treatment linkages that exist among HIV/AIDS programs and related programs in Delaware. It summarizes how funding is split among core medical and supportive services and how local prevention and treatment programs coordinate services. It presents information on the critical importance of finding 964 individuals lost to care and bringing them back into treatment. Last, it summarizes needs, barriers to services, and gaps in services. Overall, it shows how:

- Prevention interventions are linked to the effectiveness of treatment activities.
- Funding availability impacts treatment.
- Emerging trends must be monitored to assure that treatment activities are established and funded where needed.
- Funding restrictions limit efficiency and continuity of services.

Highlighted findings from the treatment portion of the Comprehensive Plan are as follows:

- Funding continues to remain critical to the success of treatment and prevention. Specifically,
    - Funding availability is needed for both core medical services and supportive services. Restricting funding to 75% for core medical services and 25% for supportive services is both beneficial and problematic at the same time.
    - Funding fluctuations affect the ability to meet need. Gaps in services are filled or created as funding availability ebbs and flows or is shifted from one service to another.
    - Funding limitations have significantly impacted integrated services for clients with mental illness and substance abuse.
    - There will be increasing demands on funding as more clients lost to care come into the system, as clients live longer, and as clients face other medical issues resulting from treatment side effects.
    - Delaware has an estimated 964 clients lost to care whose re-connection to care could add an additional $2.6 million to $4.4 million to Ryan White costs, exclusive of additional staff costs.

- Regarding medical treatment:
  - Approximately 60% of all Delaware's PLWHA are linked into an integrated model of care, receiving treatment services at one of six Christiana Care Health System (CCHS) wellness clinics, the Veterans Affairs Medical Center, or the A.I. DuPont Hospital for Children.
  - The 35% receive services through private doctors who often do not have the multidisciplinary staff to handle complicated patients with co-morbid conditions or social issues, such as underinsurance or lack of transportation.
  - 5% receive treatment through the State Department of Correction
- Among persons living with AIDS, the three top risk modes—IDU, heterosexual and MSM—are likely to be even in two to three years.
- 41% of all HIV/AIDS cases reported in Delaware through 2007 originated from Wilmington Metropolitan area minority populations.

GOALS, OBJECTIVES AND EVALUATION

The Comprehensive Plan concludes with a chapter that outlines strategic and annual goals and objectives, priority recommendations for HIV core and related services, and evaluation methods for meeting those goals and objectives, as well as a summary of the 2008 community planning group survey.

CHAPTER I: REFERENCES

Chapter I includes acronyms that are used in the 2008 Delaware HIV/AIDS Surveillance Report and in other chapters of the 2010-2014 Comprehensive Plan.

AACRN	Advanced AIDS Certified Registered Nurse
AAHIVM	The American Academy of HIV Medicine
ACRN	AIDS Certified Registered Nurse
ACTG	AIDS Clinical Trials Group
AD	AIDS Delaware
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AIDS	Acquired Immunodeficiency Syndrome
ANAC	The Association of Nurses in AIDS Care
A/PI	Asian/Pacific Islander
BCI	Brandywine Counseling, Inc.
BGOC	Beautiful Gate Outreach Center
CADR	CARE Act Data Report
CAMP	CAMP Rehoboth
CARE	Comprehensive AIDS Resource Emergency
CB	Capacity Building
CCHS	Christiana Care Health System
CDC	Centers for Disease Control
CHTP	Comprehensive HIV Treatment Plan
CLI	Community Level Interventions
CMS	Correctional Medical Systems
CRCS	Comprehensive Risk Counseling and Services
CRWG	Community Resources Work Group
CSAT	Center for Substance Abuse Treatment
C&T	Counseling and Testing Services
CTR	Counseling, Testing and Referral
CTRPS	Counseling, Testing, Referral, Partner Services
DART	Delaware Administration for Regional Transit
DAST	Delaware Administration for Specialized Transit
DHAP	Delaware Housing Assistance Program
DHHS	U.S. Department of Health and Human Services
DHSS	Delaware Health and Social Services
DIS	Disease Intervention Specialist
DMMA	Division of Medicaid & Medical Assistance
DPH	Division of Public Health
DSAMH	Division of Substance Abuse and Mental Health
DWG	Data Work Group
EIS	Early Intervention Services
EHARS	Evaluation HIV/AIDS Report System (software)
E1T1	Each One… Teach One, Inc.
FTE	Full Time Equivalent
GLI	Group Level Interventions
HAART	Highly Active Antiretroviral Therapy
HANCB	HIV/AIDS Nursing Certification Board
HC/PI	Health Communication and Public Information
HE	Health Education
HET	Heterosexual
HIV	Human Immunodeficiency Virus
HIVMA	The HIV Medicine Association
HOPWA	Housing Opportunities for Persons with AIDS
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development.
IDSA	Infectious Diseases Society of America
IDUs	Injection Drug Users
IPS	Integrated Partner Services
ILI	Individual Level Interventions
KSCS	Kent/Sussex Counseling Services
LAR	La Red Health Center
LACC	Latin American Community Center
MCH	Maternal and Child Health.
MSM	Men Who Have Sex with Men
MSM/IDU	Men Who Have Sex with Men and Inject Drugs
MTC	Meeting the Challenges
NA/AN	Native American/Alaskan Native
NCC	New Castle County
NIR	No Identified Risk
NRR	No Risk Reported
OPA	Office of Population Affairs
P4P	Prevention for Positives
PCRS	Partner Counseling and Referral Services
PWH/A	Person Living With HIV Disease
PLWHA	People Living with HIV or AIDS
PI	Public Information
RR	Risk Reduction Services
SAMHSA	Substance Abuse and Mental Health Services Administration
SCAC	Sussex County AIDS Council, Inc.
SCBW	Study of Childbearing Women
SCHIP	State Children's Health Insurance Program
SCSN	Statewide Coordinated Statement of Need
SHAS	Supplement to HIV/AIDS Surveillance Project
SM	Social Marketing
SMI	Severe Mental Illness
STD (STI)	Sexually Transmitted Diseases (Infection)
TCM	Transitional Case Management
YRBS	Youth Risk Behavior Survey (Both National and Delaware Specific

CHAPTER II: THE 2010-2014 COMPREHENSIVE PLAN PROCESS

Chapter II summarizes the process involved in the development of the 2010-2014 Comprehensive Plan. It includes legislative requirements, a brief history of community planning in Delaware, and information on how the HIV community and related partners are involved in the process.

A. Legislative Requirements

In accordance with the Ryan White HIV/AIDS Treatment Modernization Act of 2006 ("Ryan White Program") and the Health Resources and Services Administration's (HRSA's) guidelines, the State of Delaware has prepared its federally-required prevention and treatment plans. With the Centers for Disease Control's (CDC's) and HRSA's approval, Delaware's Community Planning Group—the Delaware HIV Consortium's Planning Council (Planning Council)—has developed an integrated planning document that combines the Comprehensive HIV Prevention Plan and the Statewide Coordinated Statement of Need (SCSN or Treatment Plan) into one—the 2010-2014 Comprehensive HIV Prevention Plan and Statewide Coordinated Statement of Need (Comprehensive Plan or Plan).

Prevention Portion of the Plan (Chapter IV):
In completing the *prevention* part of the Comprehensive Plan, DPH and the Planning Council were privileged to be able to build on the solid work done to create the prior 2005-2009 Comprehensive HIV Prevention Plan (2005 Plan). To determine the continued validity of the 2005 Plan findings and recommendations, the Planning Council examined them in terms of current statistical data, emerging trends, and results of assessments conducted by the Planning Council between 2005 and 2009. While the HIV epidemic has remained relatively stable in Delaware over the last eight years, with incidence numbers decreasing annually, certain trends have been identified with impact on program development. These trends and their impact are examined in Chapter IV: Prevention and include the following:

- A shifting in ordinance of Delaware's risk populations from IDU (42%), MSM (30%), and HET (16%) to HET (36%), MSM (27%), and IDU (27%).
- A sharp rise in newly diagnosed infections among African American females in 2008.
- A shift of incidence from a small number of relatively high-incidence areas to a larger number of relatively low-incidence areas.

Treatment Portion of the Plan (Chapter V): The treatment portion of the Comprehensive Plan employs HRSA's directive of prioritizing and funding HIV core services (Primary Medical Care, Medications, Oral Health Care, Substance Abuse, Mental Health and Case Management). It covers the status of treatment services and other support services that enable access to these core services.

Although the Comprehensive Plan was scheduled for completion in summer 2009, HRSA requested submission of the SCSN or treatment portion by January 5, 2009. Having approved the "Comprehensive Plan" concept for Delaware, HRSA allowed submission of a Preliminary SCSN—approved by the Planning Council—at that time. The Comprehensive Plan contained herein includes the Preliminary SCSN as Chapter V, with sections updated and shifted for logical integration into the Plan. In particular, reference to HRSA's 2005-2010 Strategic Plan has been removed from Chapter V and stands independently as Chapter VI: Goals, Objectives and Evaluation.

B. The Plan Process

The Comprehensive Plan is the result of a collaborative effort among agencies and organizations involved in the prevention and treatment of HIV/AIDS statewide, spearheaded by the Delaware HIV Consortium's Planning Council (Planning Council) and the State of Delaware Division of Public Health (DPH). From 2005 through 2009, the Planning Council worked on the Comprehensive Plan. The process included a number of steps involving on-going review of key data source information and the development and implementation of seven assessment tools, as follows:

1. Review of HIV/AIDS Epidemiological Data/Emerging Trends
   The Planning Council examined the following information**:**

   a. The 2008 Delaware HIV/AIDS Surveillance Report (the 2008 Surveillance Report), formerly the Epidemiological Profile, which provides primary information on the nature of the HIV/AIDS epidemic in Delaware and changing patterns.
   b. Emerging trends noted in Epidemiological Profile updates in 2008 and 2009, as well as monthly surveillance reports.
   c. Presentations made to Planning Council regarding the shifting in ordinance of Delaware's risk populations and the shifting of incidence from a small number of relatively high-incidence areas to a larger number of relatively low-incidence areas for examination.

2. Assessment Survey Tools
   The findings of seven survey assessment tools were incorporated in the Comprehensive Plan:[1]

   a. 2006-2008 Delaware Resource Guide/2009-2011 Delaware Resource Guide
   During this planning cycle, the Planning Council updated and reprinted the HIV/AIDS resource guide twice. In 2006, the Planning Council Community Resources Work Group (CRWG) updated the resource guide with information on 150 public/private organizations. The CRWG met six times from April 2005 to March 2006 and printed and distributed 6,000 guides. During 2008 and 2009, the Planning Council Data Work Group (DWG) updated the Guide again to include over 200 programs. Additional Spanish interpretation was included throughout, and 9,000 copies were printed for distribution. The guide also is on the Consortium's webpage (www.delawarehiv.org) and can be updated continuously

   b. 2006 Agency Capacity and Capability Survey
   Other CRWG members conducted the 2006 Agency Capacity and Capability Survey to assess Delaware's HIV prevention, treatment and support services, with 59 Resource Guide agencies completing it from September 2006 to February 2007. The CRWG met six times on the survey, submitting a report to the Planning Council on April 26, 2007.

   c. 2006 Consumer Survey
   The Planning Council DWG developed the 2006 Consumer Survey to gain information from clients on services received, needed and considered priorities—one version for the general population, one for Hispanics, and two for the incarcerated (linked to incarceration time). From August 1 to November 9, 2006, trained teams conducted 278 personal interviews at facilities/clinics, reaching 8.7% of Delaware's 3,184 persons with HIV/AIDS at that time. The DWG met seven times on the survey, submitting a report to the Planning Council on June 22, 2006.

   d. 2008 Provider Perspective Survey
   Other DWG members developed the 2008 Provider Perspective Survey—which mirrored the 2006 Consumer Survey—for completion by providers who served a core of HIV/AIDS clients. The survey asked about caseloads as a whole, focusing on the availability of services, not just perceived importance. Of 84 providers solicited, 37 (43%) completed the survey between June 9 and August 15, 2008. DWG met four times on the survey between April 2007 and October 2008, submitting a report to the Planning Council on December 4, 2008.

[1] *Survey summary information is provided in the Comprehensive Plan. Copies of complete survey instruments, survey reports and gaps analysis are available from the Delaware HIV Consortium at 302-654-5471.*

e. 2008 Prevention (At-Risk) Survey
A third group of DWG members met three times on a first-time Prevention (At-Risk) Survey to assess risky behaviors regarding safe sex practices and drug usage related to HIV/AIDS. Agencies providing outreach, counseling and testing, information and referral, and prevention education distributed surveys at their sites and at public events from June 27 to September 30, 2008 (i.e. National HIV Counseling and Testing Day events, health fairs, and educational forums). DPH scanned 800 surveys; an analysis was conducted in 2009; and a report was presented to the Planning Council on May 7, 2009.

f. Gaps Analysis
A 2008 Gaps Analysis was completed, which compared and analyzed findings from the 2006 Agency Survey, the 2006 Consumer Survey and the 2008 Provider Perspective Survey to determine met needs, unmet needs, barriers to services, and gaps in services. The analysis was presented to the Planning Council on December 4, 2008. Summary findings from the analysis are on pages 89 through 94.

g. Focus Groups
Focus groups may be used in the review process for the Comprehensive Plan and in annual updates to it.

3. Review of Prior Prevention Plan Findings
The findings from the 2005 Plan were reviewed to determine the continued validity of the recommendations and their need for change.

4. Completion of Comprehensive Plan
The Preliminary SCSN was presented to the Planning Council at its December 4, 2008 meeting. In 2009, the Planning Council completed the remaining plan tasks to finalize the Comprehensive Plan, at which time the prevention portion was presented at the September 22, 2009 Planning Council Meeting and approved for submission with the 2009 CDC prevention application.

5. Incorporation of Findings/Distribution of Documents
Comments from town meetings and from further reviews by Planning Council members will be incorporated into the Comprehensive Plan before printing, distribution, and uploading to DPH's and the Consortium's webpages (www.dhss.delaware.gov/dph and www.delawarehiv.org), following the Planning Council's December 8, 2009 meeting.

6. Participation
Participants in the process include members of the Planning Council (125+ membership) and its workgroups, persons with HIV/AIDS, public and private agencies/organizations throughout the state that serve persons with HIV/AIDS, DPH, and other governmental representatives.

7. Timeline
The timeline for completion of the various Comprehensive Plan tasks was revised in due to a vacancy in the Consortium's Manager of Community Planning position in 2007. The chart on the following page shows the revised, final timelines for the major tasks. A more detailed breakout is available from the Delaware HIV Consortium. Additionally, the chart shows some of the work as being done by the Community Resources Work Group. This work group became a part of the Data Work Group in 2008 as a part of a streamlining process.

2010-2014 Comprehensive Plan Timeline

<table>
<tr><th>Year of the Process</th><th>Community Resources Work Group</th><th>Data Work Group</th><th>Membership Work Group</th></tr>
<tr><td>Year 1 (2005)</td><td>Update 2006-2008 Resource Guide</td><td>Secondary Data Analysis and Epidemiologic Profile Review</td><td>Recruitment, Orientation, Retention</td></tr>
<tr><td>Year 2 (2006)</td><td>2006 Agency Capacity and Capability Survey (Agency Survey)</td><td>2006 Consumer Survey and Longitudinal Data Review</td><td>Voting Member and Co-Chair Elections</td></tr>
<tr><td rowspan="4">Year 3 (2007) and Year 4 (2008)
(Work carried over from these two years into 2009 due to the staff vacancy in 2007)</td><td>2008 Provider Perspective Survey</td><td>Focus Groups; Interventions and Best Practices Literature Review[2]</td><td rowspan="4">Recruitment, Orientation, Retention, Voting Member and Co-Chair Elections, as needed

Streamline Planning Council operations per State Request for Proposal</td></tr>
<tr><td colspan="2">2008 Gaps Analysis</td></tr>
<tr><td colspan="2">Set Priorities</td></tr>
<tr><td colspan="2">Make Recommendations for Prioritized Populations and Services

Update 2009-2011 Resource Guide</td></tr>
<tr><td>Year 5 (2009)</td><td colspan="2">Write 2010-2014 Comprehensive HIV Prevention Plan and Statewide Coordinated Statement of Need</td><td>Voting Member and Co-Chair Elections</td></tr>
</table>

C. Community Planning Background/Development of the Delaware HIV Consortium

The purpose of HIV community planning is to create a seamless continuum of services for those at risk for and infected with HIV. It was instituted on the belief that local decision-making is the best way to respond to local HIV prevention and care needs. Regarding care needs, the Ryan White CARE Act of 1990 (federal provider of HIV/AIDS treatment dollars) required states to form community consortia to facilitate community involvement in the allocation of federal monies. Consortia are required to work with local service providers, those affected and infected with HIV, and others who have a stake in HIV services to determine what services are most needed within a jurisdiction and to work with other Ryan White Parts to develop the SCSN or Treatment Plan for a jurisdiction.

In 1993, the CDC similarly mandated that any state receiving federal funding for HIV/AIDS prevention must develop a community planning group to develop a Comprehensive HIV Prevention Plan. The plan examines the epidemic within the state, reviews the needs of the populations most at-risk for contracting HIV/AIDS, sets priorities for those target populations, and determines what types of prevention activities or interventions will work best for each population. Local funding is then allocated for prevention activities based on the priorities set in the plan, with the local community planning group providing oversight.

[2] *The Comprehensive Plan does not provide an appendix of potential interventions from a best practices literature review. Rather, it proposes a defined and cohesive combination of approaches that maximize what has proven effective in Delaware; and directions are provided to the CDC-approved evidence-based interventions websites (referenced on page 58), which lists effective approaches for defined populations and which are continuously reviewed and updated by the CDC. These interventions, as well as any other evidence-based or theory--based interventions that can be justified by an agency for a population, may be proposed for use by an agency.*

Delaware was not required to form a consortium because of its size, but DPH asked a local group—the Providers Network of Delaware—to provide recommendations to DPH regarding Ryan White expenditures. In 1991, this group became the Delaware HIV Care Consortium. In 1994, a plan was presented to merge the Care Consortium with two other HIV/AIDS organizations—the AIDS Advisory Task Force and the HIV Community Prevention Planning Committee. From this plan, the Delaware HIV Consortium emerged, which has spearheaded the community planning process in Delaware since that time. The Consortium is dedicated to eliminating the spread of HIV/AIDS and to creating a seamless continuum of care for all people infected and affected with HIV in Delaware. Governed by a Board of Trustees, it members includes HIV/AIDS service providers, civic leaders, public health professionals, representatives of private business, and persons living with HIV disease. Coordination, community participation and consumer involvement are its cornerstones.

D. History of the Planning Council of the Delaware HIV Consortium

Until late 2004, two separate Consortium statewide planning committees oversaw the community planning processes. The Treatment Services Committee oversaw the Ryan White treatment process; the Prevention Planning Group oversaw CDC prevention funding requirements, particularly development of the Comprehensive HIV Prevention Plan. Each committee was comprised of many of the same HIV service providers, educators, community leaders, and persons infected with or affected by HIV. Both groups had co-chairs, sub-committees, working groups, and work group leaders. Much of each group's work was duplicated by the other, only with slightly different focuses. Eventually, it became obvious that the groups should merge. After 1½ years of collaborating on a merger concept, mission, and goals, the groups integrated in December 2004 to form the Delaware HIV Consortium's Planning Council. The Planning Council's mission and goals follow:

Planning Council Mission

The mission of the Delaware HIV Planning Council of the Delaware HIV Consortium is to eliminate the spread of HIV/AIDS and to create a seamless continuum of care for all people infected and affected in Delaware, by:

- Preventing new and secondary infections, diagnosing existing infections at the earliest possible stage through testing and counseling programs, and developing early intervention for existing infections to decrease morbidity and mortality.
- Linking HIV prevention, testing and counseling, early diagnosis, access to care and the provision of quality treatment services.
- Engaging and including individuals from every sector of our community in our planning process, particularly those persons whose lives have been directly touched by HIV/AIDS.

Planning Council Goals

- We will develop the Delaware Comprehensive HIV Plan for prevention and treatment services, by:
  - Determining the size and demographics of the epidemic in Delaware.
  - Determining the needs (met and unmet) of those who are identified as high risk for HIV and those already infected, especially among the underserved and minority populations.
  - Establishing priorities for prevention and treatment services to identified high-risk and infected populations.
  - Making recommendations in the prevention and treatment systems to best meet the prioritized needs within the State.
- We will periodically assess the recommendations made in the Delaware Comprehensive HIV Plan for their effectiveness, prioritization and relevance to the current environment and emerging trends.
- We will promote the statewide coordination and collaboration of service providers in order to make effective services available and accessible for those persons who need them.
- We will respond to HIV service issues, trends and events as they are identified, by communicating those strategies whenever possible and appropriate to key stakeholders.

In 2008, the Planning Council further streamlined operations. The Planning Council Manager of Community Planning (Manager) now conducts more of the work formerly done by committees or by Planning Council work groups, although work groups continue to provide valuable input, guidance, and support. The Data Work Group (into which the former Community Resources Work Group merged) helps with surveys, assessments, and analyses. The Membership Work Group conducts member orientations, develops and implements recruitment plans, nominates voting members, and updates the Planning Council's Attendance and Voting Policies and Procedures, as required. Work groups meet face-to-face, by phone conferences, or by e-mails and play vital roles in development of the Resource Guide, the Agency Survey, the Consumer Survey, the Provider Perspective Survey, and the Prevention (At Risk) Survey. They review and approve the Gaps Analysis and Prevention Survey Analysis and are involved in Focus Group work, as needed.

the Planning Council's Attendance and Voting Policies and Procedures outline requirements. The Planning Council is comprised of 39 voting members and an unlimited number of non-voting members. Voting membership is reflective of the epidemic in Delaware, with voting members filling specific categories. The Voting Membership is scheduled for turnover in February 2010. As of May 2009, 28 of the categories were filled as follows:

Planning Council Voting Member Categories

Voting Member Category	Filled	Voting Member Category	Filled
Person Living With HIV/AIDS	7 of 13	Youth	1 of 1
Academia	0 of 1	Incarcerated	1 of 1
Private Section	0 of 1	Hispanic	1 of 1
Government	2 of 4	Housing/ Homeless	1 of 1
Ryan White Parts B, C, D	3 of 3	Health Care Provider	0 of 1
CDC-Funded	1 of 1	AIDS Service Organization	1 of 1
Case Manager	1 of 1	Substance Abuse Provider	1 of 1
Mental Health Provider	1 of 1	Affected	1 of 1
Injection Drug User	1 of 1	At-Large	2 of 2
Men Sleeping with Men	1 of 1	Non-Elected Community Leader	1 of 1
Heterosexual	1 of 1		

E. Consumer Involvement Opportunities in HIV Planning and Treatment

Opportunities are available to enable PLWHA participation in Delaware HIV Consortium planning activities, as well as community-based treatment activities.

1. Consumer Involvement in HIV Planning Activities

   a. Delaware HIV Planning Council

   PLWHA actively participate in the community planning process as members of the Delaware HIV Planning Council and any of its work groups. Planning Council rules require that one of the four Co-Chairs be a PLWHA and that 33% (13) of its voting members be PLWHA. As of May 2009, the PLWHA Co-Chair position plus six of the 13 PLWHA voting member positions are filled; five more PLWHA attend Council meetings on a regular or semi-regular basis. The Planning Council's Membership Work Group recruits more PLWHA to the Council, using a "Recruitment Flyer" and other tools to invite consumers to join.

b. Policy Committee

For 14 years, the Policy Committee has enhanced the Delaware HIV Consortium's organizational capacity to evaluate and determine HIV/AIDS policies. The committee works with staff to monitor and assess private and public policy initiatives on local and national levels, determine the potential impact of specific policies for HIV/AIDS, and develop positions on subjects of priority interests. It welcomes PLWHA to work with service providers, faith-based organizations, civic leaders, mental and public health professionals, school administrators, and other members in assuring that effective policies are in place for the HIV/AIDS community.

c. Red Ribbon Advocates

The Delaware HIV Consortium created the Red Ribbon Advocates program in January 2005 as a training program to build PLWHA's advocacy skills. Red Ribbon Advocates learn skills in public speaking, letter writing, and phone calling. From 2005 through 2007, twenty PLWHA graduated from the program. Advocates participated in rallies in New York and Dover regarding prevention and treatment needs; spoke to state legislature in support of Delaware's Needle Exchange Program; and addressed both Wilmington City Council and Delaware's Congressional leaders' staffs in Washington, DC regarding PLWHA housing needs. Suspended in 2008 due to a staff transition, the program will be re-instituted in the fall of 2009.

2. Consumer Involvement in HIV Healthcare

a. Patient Advisory Groups

Christiana Care Health System's (CCHS's) HIV Program has three Patient Advisory Groups (PAGs), one for each county in Delaware (New Castle, Kent, and Sussex). PAGs provide a forum for PLWHA who access care with CCHS's HIV Program to provide input into program development, implementation, and evaluation. PAG meetings are co-facilitated by a patient and a designated HIV Program staff member. (Patient co-facilitation may rotate.)

Each PAG determines membership guidelines, committee rules, frequency of meetings, location and time. Transportation is coordinated as needed, and dinner is provided. Topics for discussion are identified in advance and meeting agendas are developed prior to each meeting. Meeting minutes are provided to members and to the HIV management team. Feedback obtained from the PAGs is directly incorporated into the CCHS HIV Program performance improvement process. In addition, a yearly patient satisfaction survey is conducted at each site. The PAGs review the results of these surveys and assist in identifying opportunities for improvement. Action plans are then developed to address these issues, which are then presented to staff at each site for review and implementation.

b. Peer Education Wellness Foundation/CCHS Involvement

For the last five years, the Wellness Foundation of Delaware has recruited and trained PLWHA to provide peer education in Delaware's clinic system, working with the CCHS HIV Program. The goal of peer education is to assist clients in developing an understanding of how issues affect them personally and to help them with a variety of matters such as medication adherence, managing side effects, undertaking healthy behavioral lifestyles, and understanding the role of proper nutrition and fitness. In 2008, the Wellness Foundation suspended operations. Its two active peer educators have continued working with CCHS clinics. However, there is some uncertainty regarding continuation of the program, although it is the intention of CCHS to continue it at whatever levels can be maintained.

CHAPTER III: EPIDEMIOLOGY , EMERGING TRENDS, AND CHANGING ENVIRONMENT

Chapter III contains the 2008 Delaware HIVAIDS Surveillance Report, emerging trends, and the changing environments.

A. 2008 Delaware HIV/AIDS Surveillance Report

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CHAPTER III: EPIDEMIOLOGY , EMERGING TRENDS, AND CHANGING ENVIRONMENT

2008 Delaware HIV/AIDS Surveillance Report Executive Summary

In 2008, 1,317 Delawareans were living with HIV and another 2,153 were living with AIDS. In that same year, the cumulative number of HIV/AIDS cases in Delaware reached 5,112. Despite the fact that it is the 2nd smallest state in the U.S. in terms of geographic size, Delaware's AIDS incidence rate (19.8 cases per 100,000 residents) is among the highest in the nation. Furthermore, recent data indicate that, compared to other states, the frequency with which new AIDS cases are diagnosed in Delaware is increasing. In 2006, Delaware's AIDS incidence rate was the 10th highest among U.S. states. By 2007, Delaware's AIDS incidence rate had increased to a level which ranked 6th highest in the nation.

The statewide distribution of Delaware's HIV/AIDS cases closely follows county-level population estimates. New Castle County – the most populated of Delaware's three counties – has the highest percentage of Delaware's HIV/AIDS cases. Cases in New Castle County are largely confined to the densely populated Wilmington metropolitan area. Wilmington comprises just 14% of the New Castle County population, but accounts for 67% of the county's HIV/AIDS cases. In 2008, 32% of all newly diagnosed HIV cases occurred among minorities residing in the City of Wilmington.

Males account for the majority (71%) of HIV/AIDS cases ever diagnosed in Delaware. However, in recent years, Delaware females have accounted for an increasingly large percentage of total HIV/AIDS cases. For example, in 1990, 24% of newly diagnosed AIDS cases were female; in 2008, females accounted for 34% of newly diagnosed cases.

African-American Delawareans carry a disproportionate share of the state's HIV/AIDS burden. Despite representing just one-fifth of Delaware's total population, African-American Delawareans accounted for 69% of all HIV/AIDS cases ever diagnosed in the state. This racial disparity is more pronounced in Delaware compared to the U.S., and persists for both HIV and AIDS when considered as two separate disease states. African-American males account for 36% of all male AIDS cases in the U.S., but 62% of all males AIDS cases in Delaware. Similarly, African-American women comprise 60% of all female AIDS cases in the U.S., but nearly 80% of all female AIDS cases in Delaware.

Consistent with U.S. trends, the majority (70%) of HIV/AIDS cases ever reported in Delaware were diagnosed among adults aged 30-49. In Delaware and the U.S., fewer than 3% of HIV/AIDS cases ever reported were diagnosed among adults age 60 and older.

Pediatric HIV/AIDS cases – defined as cases diagnosed among children under the age of 13 – account for just 1% of cases ever reported in both Delaware and the U.S. In Delaware, 76% of all pediatric HIV/AIDS cases were diagnosed among African-American children. From 2007-2008, 49 Delawarean women infected with HIV gave birth to infants; 100% of infants born to these HIV-infected mothers tested negative for the disease. No HIV-positive infants have been born in Delaware in the past three years.

Among all new HIV infections diagnosed in Delaware in 2008, the largest percentage of cases (36%; N=64) were attributable to men having sex with men. Heterosexual transmission and injection drug use accounted for an additional 32% (N=53) and 13% (N=22) of newly diagnosed HIV cases, respectively. An additional 2% of new cases (N=3) were attributable to both MSM and injection drug use. The remaining 17% (N=24) of cases fell into the "Other Risk" or "No Risk Identified" behavioral categories.

Within Delaware, the mode of HIV transmission varies among the three counties. In New Castle County, African-American injection drug users account for the majority of new HIV diagnoses. In Sussex County new cases are predominantly diagnosed among Caucasian men who have sex with men.

CHAPTER III: EPIDEMIOLOGY , EMERGING TRENDS, AND CHANGING ENVIRONMENT

From 1981 through December 2008, 2,049 Delawareans have died from AIDS. In the past decade, the survival rate for Delawareans living with AIDS has dramatically increased. In addition to improvements in the life expectancy for Delawareans with AIDS, Delawareans with HIV are also living longer prior to progression of the disease to AIDS. Earlier diagnoses, improved medical management of HIV, and the development of extremely effective anti-retroviral drugs have contributed to the dramatic improvement in HIV/AIDS survival rates.

Background and Introduction

Delaware initiated AIDS surveillance and reporting efforts in 1981. In 2001, the Delaware Division of Public Health (DPH) expanded surveillance efforts and began collecting data for Delawareans infected with HIV. HIV/AIDS surveillance efforts heavily rely on data compiled from healthcare professionals and laboratories throughout the state.

The Human Immunodeficiency Virus (HIV) is the underlying biological agent that weakens an individual's immune system, facilitating the development of Acquired Immune Deficiency Syndrome (AIDS). Except for initial viral response, HIV may not manifest itself with symptoms for some time after infection. Following the progression of HIV to AIDS, symptoms of the virus typically advance to a state where a clinical diagnosis may be made by a physician. AIDS symptoms include specific infections, cancers, and cellular changes in a person's immune system.

Analysis of HIV/AIDS incidence and prevalence data is a crucial component to combating the disease. The Delaware HIV Consortium and its Planning Council rely on accurate surveillance data to guide the development of HIV prevention efforts, as well as HIV/AIDS healthcare planning and services administration. Surveillance data allow DPH to monitor risk reduction and disease prevention progress, and also influence the amount of federal funds that Delaware receives to assist in the fight against HIV/AIDS.

This report largely focuses on three main areas of interest: (1) the socio-demographic characteristics of Delawareans; (2) the scope of the HIV/AIDS epidemic in Delaware; and (3) the pattern of service utilization among Delawareans living with HIV/AIDS.

HIV/AIDS Surveillance in Delaware

Delaware's HIV/AIDS surveillance efforts largely focus on three fundamental epidemiological concepts: person, place, and time.

- **Person**: Identifying the mode by which an individual contracts HIV is a crucial first step in an investigation, as this information is used to guide future prevention efforts. In Delaware, HIV/AIDS surveillance staff help characterize mode of HIV transmission using case report forms, personal interviews, and medical record reviews.

- **Place**: It is also important to determine the geographic area where HIV transmission occurred. In this report, "place" generally refers to the county of residence at time of HIV/AIDS diagnosis. Every effort is made to identify the precise location of HIV/AIDS transmission among Delawareans, regardless of whether diagnosis and/or treatment occur within the state. That is, Delaware engages in data-sharing agreements with other states to identify Delawareans who may have been diagnosed or who seek treatment outside of the state.

- **Time**: In terms of HIV/AIDS surveillance, DPH relies on two dates to help characterize disease trends in Delaware: (1) date of diagnosis and (2) date of report (to the DPH HIV/AIDS Surveillance

Office). Excessive time-lag between these two dates complicates the process of data analysis and accurate surveillance. For this reason, the HIV/AIDS Surveillance Office works with healthcare practitioners and laboratories across the state to facilitate timely reporting of all newly diagnosed cases. The successes of timely reporting and active surveillance methods allow the majority of this report to include data pertaining to date of diagnoses.

Patient confidentiality is crucial for maintaining an effective HIV/AIDS surveillance system. The DPH HIV/AIDS Surveillance Office adheres to detailed data confidentiality protocols that mandate physical, operational, and personnel security standards when working with HIV/AIDS data. Data confidentiality standards must be maintained as a condition of receiving federal funding for surveillance efforts.

Methods

Data Source Descriptions, Limitations and Precautions

In addition to HIV/AIDS surveillance data collected by DPH, this report includes data from the U.S. Census Bureau, the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration of the U.S. Department of Health and Social Services (DHSS). A brief description of each data source is found below.

Delaware Division of Public Health (DPH): provides statewide HIV testing and counseling data via the Delaware HIV Counseling and Testing System database. Healthcare practitioners and centers use standardized data collection forms to report information for Delawareans tested in public clinics across the state, as well as for those seeking HIV counseling.

This report also contains data derived from Delaware-specific *Sexually Transmitted Infection and Disease Reports*, DPH publications that include statewide data pertaining to sexually transmitted diseases (STDs; e.g., gonorrhea, chlamydia, and syphilis). STD data are helpful for identifying populations at increased risk for contracting HIV.

Birth and death information, originating directly from birth and death certificates provides Delaware-specific morbidity and mortality data. Doctors, hospitals, and clinics in Delaware are required to report birth and death certificate data. However, in terms of mortality data, it is important to note that the data quality is dependent upon death certificate data provided by physicians. Some physicians may not note a diagnosis of HIV/AIDS on death certificates. This may be due to family request, physician lack of knowledge regarding HIV status, or failure to record underlying causes of death. For these reasons, the number of AIDS-related deaths may be artificially suppressed not only in Delaware, but across the nation.
U.S. Census Bureau: provides Delaware-specific county-level population data. Data are complete and standardized nationwide through 2000. Data from the most recent Census year (2000) are used to provide interim one-year estimates for non-Census years (e.g., 2001-2009).

The Centers for Disease Control and Prevention (CDC): provides national-level HIV/AIDS trend data via the Evaluation HIV/AIDS Reporting System (EHARS). EHARS is used nationwide for storing HIV/AIDS surveillance data. State-specific HIV/AIDS data (both prevalence and incidence data) are available through EHARS. While it represents an advanced public health surveillance system, it is possible that actual HIV/AIDS prevalence and incidence counts are underreported in EHARS. Delays in reporting and noncompliance contribute to this underreporting. While HIV data are reported to the CDC by all 50 states, the quality of HIV surveillance data for some states has not met the minimum level for inclusion in analyses.

The quality of Delaware's EHARS data has improved substantially in recent years, largely in response to the proactive efforts of the HIV/AIDS Surveillance Office and field workers. Via increased record reviews and education of healthcare professionals and laboratories regarding the proper methods for reporting HIV/AIDS cases, case report forms in Delaware reflect more accurate data regarding newly diagnosed HIV/AIDS cases. It is important to note, however, that Delaware-specific HIV data in EHARS does not represent all Delawareans who test positive for the disease. While Delaware HIV cases detected through confidential testing are reported to EHARS, Delaware cases detected through anonymous testing are not reported to EHARS.

This report also utilizes data from the CDC-published *HIV/AIDS Surveillance Report*. Data from the *HIV/AIDS Surveillance Report* summarizes national and state-level trends with respect to the HIV/AIDS epidemic.

Data derived from the Youth Risk Behavior Survey (YRBS) are also included in the current report. YRBS represents an ongoing surveillance effort by the CDC with the overall goal of identifying risk factor trends among youth (e.g., nutrition patterns, substance use, accidents, sexual behaviors, and delinquency). These data are then used to explore the relationship between risk behaviors and health. YRBS uses self-administered, anonymous questionnaires to collect data from high school students in odd-numbered years. The Delaware Department of Education oversees the implementation of YRBS. In Delaware, YRBS response rates are very high; 84% of students approached for participation complete a questionnaire.

Health Resources and Services Administration (HRSA), U.S. Department of Health and Social Services (DHSS): provides data related to HIV/AIDS service utilization patterns via the Ryan White Data Reports (RDR). States receiving federal Ryan White dollars use these funds to provide medical and support services to those infected with HIV/AIDS. Ryan White funds are also used to provide health insurance coverage and prescription drugs for those with the disease. HRSA receives information from states and uses the data to monitor HIV/AIDS service utilization patterns across the nation. While RDR data are limited to those individuals with HIV/AIDS who seek healthcare, these data are nonetheless important for future healthcare planning.

Data Specifics

- In 1993, the CDC expanded the AIDS case definition to include individuals diagnosed with the disease who did not yet display several AIDS indicators (including severely compromised immune system with CD_4 counts <200 µ/L or <14%, invasive cervical cancer, recurrent pneumonia, and pulmonary mycobacterium tuberculosis).

  The expansion in case definition created a rapid increase in the prevalence of AIDS cases, nationwide, in the early 1990s. This sharp increase in AIDS prevalence was observable at the local, state, and national levels. It is important to note that the AIDS case definition was modified again in 2007; however, the impact of the most recent case definition on Delaware's HIV/AIDS statistics is not yet known.

- In 2001, 20 years after the initiation of AIDS surveillance efforts, Delaware initiated HIV surveillance efforts. In this report, 2001-2008 HIV data are combined with AIDS data. For reporting years prior to 2001 (i.e., 1981-2000), data reflect AIDS case counts only. The inclusion of HIV cases beginning with reporting year 2001 created a sharp increase in HIV/AIDS case counts. However, note that this increase in cases is a methodological artifact and does not represent a true increase in the actual number of HIV/AIDS counts in Delaware.

- Per DPH data release policies, data in this report may be combined or suppressed to ensure patient confidentiality. No Delaware-specific HIV/AIDS data are released in a format that may allow for individual identification. In this report, any combined or suppressed data are noted in footnotes.

Definition of Terms

Adolescent:	An individual between the ages of 13 and 19.
Adult/Adolescent case:	Patient is 13 years or older at the time of diagnosis.
Epidemiology:	A branch of medical science that deals with incidence, distribution and control of a disease in a population.
Heterosexual:	Persons with a history of sexual contact with a person of the opposite sex.
Incidence Rate:	A measure of the rate of development of a disease in population over a period of time. Calculated by dividing the number of new cases diagnosed in a population during a specific time period by the size of the population during the same time period.
NIR case:	No Identified Risk case. NIR cases may be reclassified as information is obtained via a complete epidemiologic investigation.
Pediatric case:	Patient is younger than age 13 at the time of diagnosis.
Prevalence:	The percentage of a population that is affected with a particular disease at a specific point in time.
Rate:	Number of cases in a population divided by the total size of the population. Rates allow for the direct comparison of groups with different population sizes.
Transfusion case:	Person who acquired the HIV virus as a result of receiving blood or blood products.
Year of diagnosis:	The year when the disease event was first confirmed by medical personnel.
Year of report:	The year when the case was reported to the Delaware HIV/AIDS Surveillance Office.

1. Socio-Demographic Characteristics of the State of Delaware

Delaware is the second smallest state in the U.S. in terms of geographic size, measuring 100 miles from north to south and 30 miles from west to east. Delaware is comprised of New Castle, Kent, and Sussex Counties. New Castle County, located in the northern portion of Delaware, is the most densely populated of the three counties and home to 62% of Delawareans. Almost 14% of New Castle County residents live in the city of Wilmington. Centrally-located Kent County, home to 17% of Delawareans includes a blend of urban, suburban, and agricultural zones. Dover Air Force Base and the state capital (Dover) are located in Kent County. The remaining 21% of Delawareans live in Sussex County, the southernmost of the three counties. Sussex County is largely rural and home to a large number of poultry, dairy, and crop-growing farms and facilities. Eastern Sussex County includes the beach communities and draws a large number of retirees each year.

In 2006, Delaware's total population included 853,476 children and adults, representing 0.3% of the total U.S. population. The majority of Delawareans (69.0%) are Caucasian; African-Americans and Hispanics comprise 21% and 6% of Delaware's population, respectively. Approximately 4% of Delawareans are Asian or Pacific Islander. Females account for 52% of Delaware's total population, equivalent to the national gender distribution. See Table 1, below, for racial distributions at the county-level.

Table 1: Racial Distribution among Delawareans, by County, 2006

County	Caucasian N (%)	African-American N (%)	Hispanic N (%)	Other N (%)	Total N (County%)
New Castle	346,888 (66%)	120,885 (23%)	36,791 (7%)	21,023 (4%)	525,587 (62%)
Sussex	140,625 (78%)	25,240 (14%)	10,817 (6%)	3,606 (2%)	180,288 (21%)
Kent	103,321 (70%)	32,472 (22%)	4,428 (3%)	7,380 (5%)	147,601 (17%)
Delaware	590,834 (69%)	178,597 (21%)	52,036 (6%)	32,009 (4%)	853,476 (100%)

The median age of Delawareans is 38. Compared to the general U.S. population, Delawareans have a slightly higher median annual household income ($50,007 vs. $55,303, respectively). Patterns of educational attainment among Delawareans are similar to that of the general U.S. population. Approximately 83% of Delawareans have a high school diploma compared to 80% of the U.S. population. Twenty-five percent of Delawareans have earned a bachelor's degree or higher compared to 24% of the U.S. population. Twelve percent of Delaware residents report speaking a language other than English in the home.

2. Scope of the HIV/AIDS Epidemic in Delaware and the U.S.

Between 1981 and 2008, 5,112 Delawareans were diagnosed with HIV or AIDS. In 2008, 2,153 Delawareans were living with AIDS. An additional 1,317 Delawareans were living with HIV that had not yet progressed to AIDS. Approximately 15% of Delawareans living with HIV/AIDS moved to the state after diagnosis.

Males account for 71% of all HIV/AIDS cases ever diagnosed in the state. African-American Delawareans represent a disproportionate share of the state's HIV/AIDS burden, accounting for 66% of all cases diagnosed since 1981. Caucasian and Hispanic Delawareans account for 28% and 6% of all HIV/AIDS cases ever diagnosed in the state, respectively. The largest percentage of HIV/AIDS cases have been diagnosed among adults ages 30-39. Delawareans in New Castle County account for the majority of HIV/AIDS cases ever diagnosed in the state. See Table 2, below, for a breakdown of Delaware's HIV and AIDS cases by gender, race, age, and county.

Table 2: Delaware Reported HIV/AIDS Cases, 1981-2008

	HIV Cases N (%)	AIDS Cases N (%)	Total (HIV/AIDS) Cases N (%)
Total Cases	**1,278 (100%)**	**3,834 (100%)**	**5,112 (100%)**
Gender			
Males	834 (65%)	2,780 (73%)	3,614 (71%)
Females	444 (35%)	1,054 (27%)	1,498 (29%)
Race			
Caucasian	371 (29%)	1,038 (28%)	1,409 (28%)
African-American	806 (63%)	3,129 (66%)	3,383 (66%)
Hispanic	87 (7%)	256 (5%)	287 (6%)
Other / Unknown	14 (1%)	25 (< 1%)	33 (< 1%)
Age Group (Years)			
< 13	14 (1%)	27 (< 1%)	41 (< 1%)
13-19	66 (5%)	20 (< 1%)	86 (2%)
20-29	319 (25%)	497 (13%)	816 (16%)
30-39	433 (34%)	1,516 (40%)	1,949 (38%)
40-49	311 (24%)	1,250 (33%)	1,561 (31%)
50+	135 (11%)	524 (14%)	659 (13%)
County			
New Castle (NCC)	949 (74%)	2,905 (76%)	3,854 (75%)
NCC,City of Wilmington	*593 (46%)*	*1,937 (50%)*	*2,530 (49%)*
NCC, non-Wilmington	*356 (28%)*	*968 (25%)*	*1,324 (26%)*
Kent County	124 (10%)	373 (10%)	497 (10%)
Sussex County	205 (16%)	556 (15%)	761 (15%)

Note: In Delaware, AIDS and HIV surveillance efforts began in 1981 and 2001, respectively.

Prevalence and Incidence

Prevalence rates describe the total number of people in a population diagnosed with a particular disease. The 2006 U.S. HIV and AIDS prevalence rates were 154.2 and 185.1 per 100,000, respectively. In other words, in 2006, for every 100,000 U.S. residents, 154 residents were living with HIV and 185 residents were living with AIDS. In comparison, Delaware's 2008 HIV and AIDS prevalence rates were 154.3 and 252.2 per 100,000, respectively. Therefore, while Delaware's HIV prevalence rate is virtually identical to that of the U.S., Delaware's AIDS prevalence rate is 36% greater than the U.S. rate.

While prevalence rates describe the percentage of a population living with a particular disease, incidence rates describe the extent to which *new* cases are diagnosed within a population. Specifically, incidence rates represent the speed with which a disease spreads throughout a population. In the U.S., the 2007 AIDS incidence rate was 12.4 per 100,000. In other words, in 2007, approximately 12 out of every 100,000 U.S. residents were diagnosed with AIDS. Delaware's AIDS incidence rate tends to be higher than that of the U.S. In 2008, Delaware's AIDS incidence rate was 19.8 per 100,000 – nearly 60% higher than the 2007 U.S. rate. In 2008, Delaware ranked 6th among all states in terms of AIDS incidence rates.

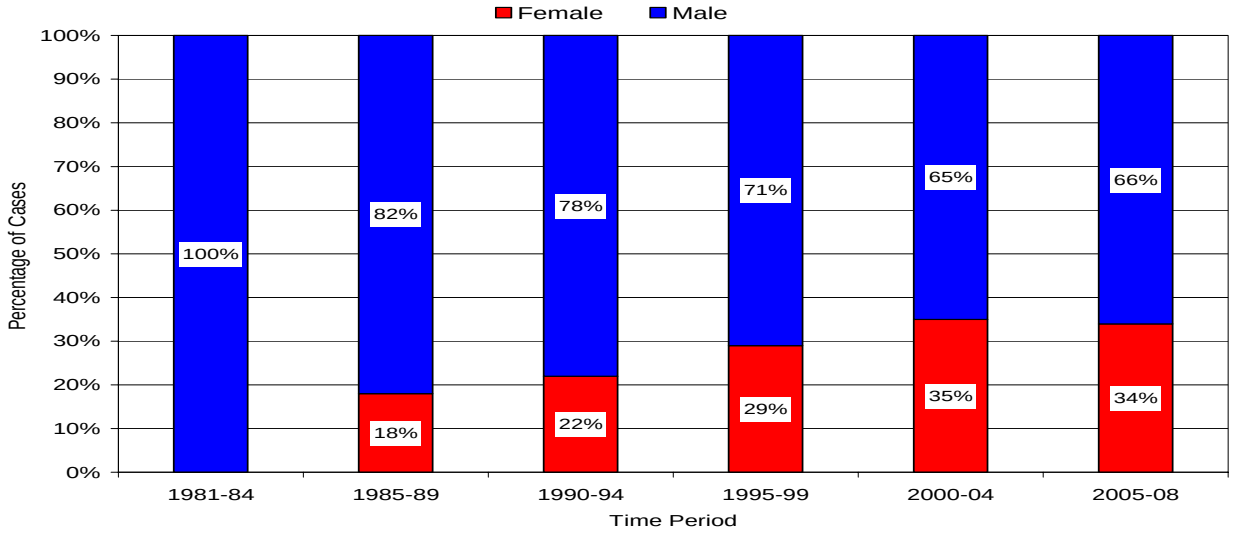
HIV/AIDS prevalence and incidence data are unavailable for smaller, hard-to-reach populations, such as the homeless, transgendered, and mentally ill. Additionally, some HIV/AIDS cases are diagnosed through routine screenings (e.g., blood donations) and little additional information is available regarding individuals' risk factors.

Gender

Since the initiation of AIDS surveillance in 1981 and HIV surveillance in 2001, males have accounted for the vast majority of cases diagnosed annually in Delaware. However, as shown in Figure 1 (next page),

Delaware females continue to account for a growing percentage of HIV/AIDS cases diagnosed each year in the state. Before 1984, no female HIV/AIDS cases were diagnosed in Delaware. From 2005-2008, females accounted for 34% of all HIV/AIDS cases diagnosed in Delaware.

Figure 1: Delaware HIV/AIDS Cases, by Gender, 1981-2008 (N=5,112)

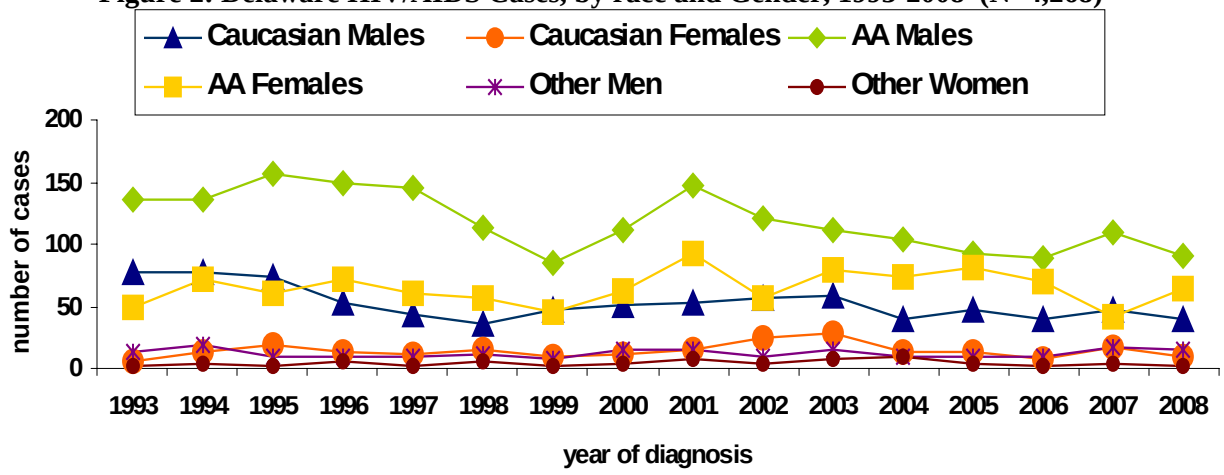


Race/Ethnicity

Delaware's HIV/AIDS epidemic continues to disproportionately affect the African- American population. African-Americans comprise 21% of the Delaware's total population, but account for 63% and 67% of the state's HIV and AIDS cases, respectively.

Since the early 1990s, African-American men and women in Delaware have accounted for proportionately more HIV/AIDS cases than their Caucasian counterparts (Figure 2). The largest number of HIV/AIDS cases continues to be diagnosed among the African-American male population. As shown in figure 2 below, males account for comparatively more cases than females within each race category (i.e., Caucasian, African-American, Hispanic, and Other).

Figure 2: Delaware HIV/AIDS Cases, by race and Gender, 1993-2008 (N=4,268)



When considered as two separate disease states, Delaware's racial disparity persists for both HIV and AIDS. Furthermore, Figures 3 and 4 with accompanying data tables below, show the magnitude of this racial disparity in Delaware is greater than that in the U.S. In terms of HIV, African-American males account for 39% of all male HIV cases in the U.S., but 60% of all male HIV cases in Delaware. African-American females account for 62% of all female HIV cases in the U.S., but 70% of all female HIV cases in Delaware. Among Delaware's pediatric cases, African-American youth account for 77% of HIV cases. The U.S. pediatric breakout is not available.

Figure 3: HIV Cases, by Race and Gender: Delaware vs. U.S., (DE=2008, US=2007)

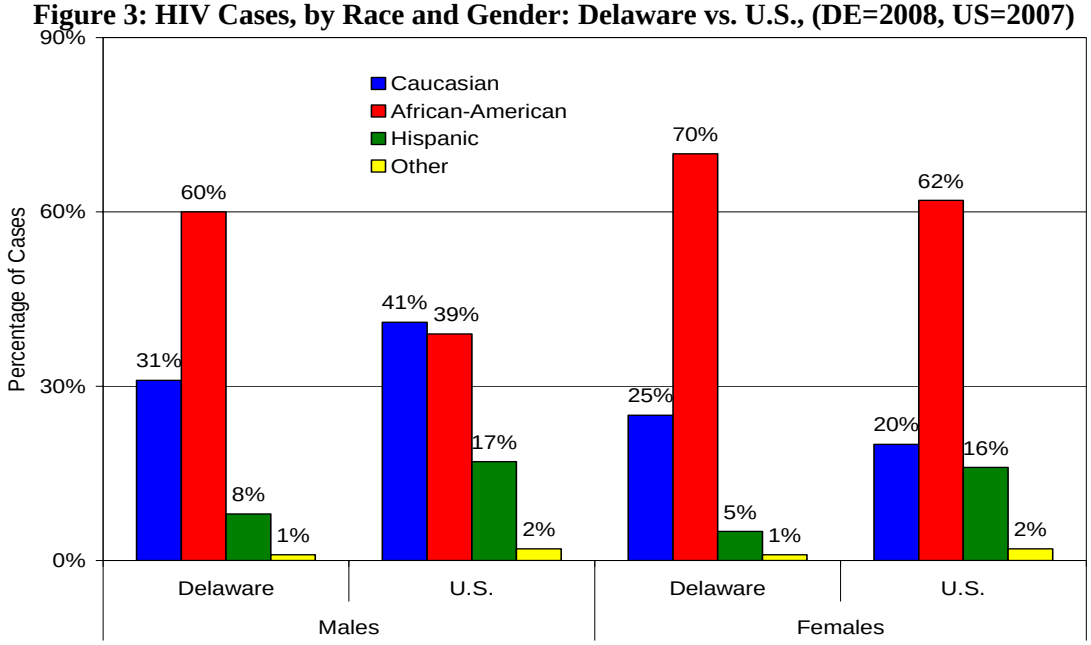


Table 3: Delaware HIV Cases Diagnosed Through 2008 by Race and Gender (N=1278)

Race	Male N (%)	Female N (%)	Total N (%)
Caucasian	262 (31%)	109 (25%)	371 (29%)
African American	497 (60%)	309 (70%)	806 (63%)
Hispanic	65 (8%)	22 (5%)	87 (7%)
Other	10 (1%)	4 (1%)	14 (1%)
Total	834 (100%)	444 (100%)	1278 (100%)

Table 4: U.S. HIV Cases Diagnosed Through 2007 by Race and Gender (N=337,590)

Race	Male N (%)	Female N (%)	Total N (%)
Caucasian	98,524 (41%)	18,680 (20%)	117,204 (35%)
African American	93,775 (39%)	56,732 (62%)	150,507 (45%)
Hispanic	41,912 (17%)	14,608 (16%)	56,520 (17%)
Other	3,271 (1%)	981 (1%)	4,252 (1%)
Unknown	2,278 (1%)	1,003 (1%)	3,281 (1%)
Total	239,760 (100%)	92,004 (100%)	337,590 (100%)*

***Includes national pediatric cases = 5,822 (no breakdown available) and 4 people of unknown sex**

Compared to HIV, Delaware's racial disparity is even more pronounced for AIDS. African-American males account for 36% of male AIDS cases in the U.S., but 62% of male AIDS cases in Delaware. African-American females account for 60% of female AIDS cases in the U.S., but 80% of all female AIDS cases in Delaware. Among Delaware's pediatric cases, African-American youth account for 76% of AIDS cases.

Figure 4: AIDS Cases, by Race and Gender: Delaware vs. U.S., (DE=2008, US=2007)

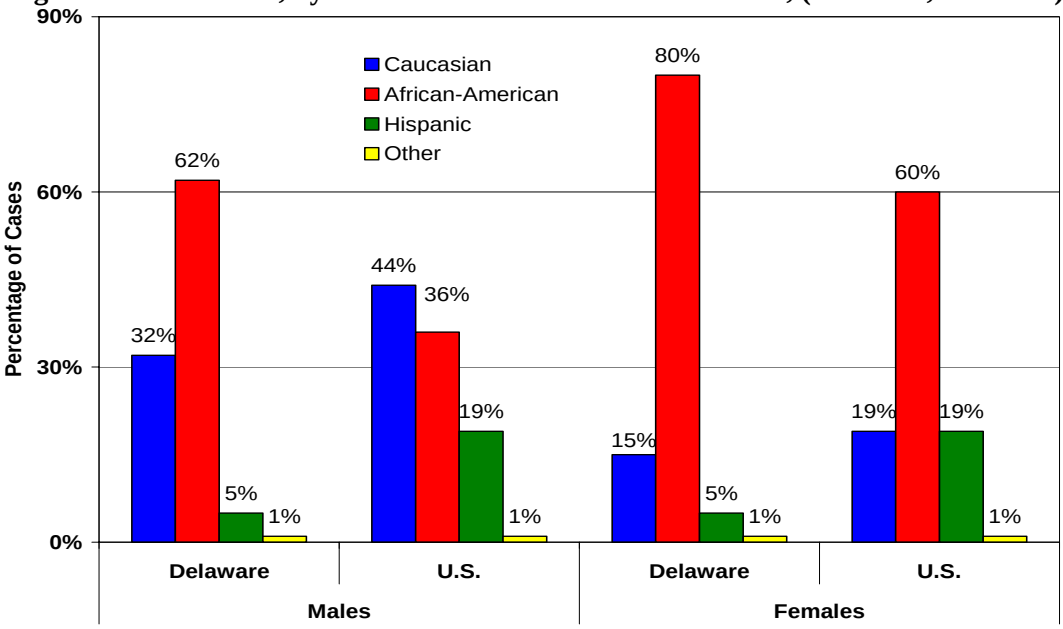


Table 5: Delaware AIDS Cases Diagnosed Through 2008 by Race and Gender (N=3,834)

Race	Male N (%)	Female N (%)	Total N (%)
Caucasian	882 (32%)	156 (15%)	1,038 (27%)
African American	1,735 (62%)	842 (80%)	2,577 (67%)
Hispanic	152 (5%)	48 (5%)	200 (5%)
Other	11 (<1%)	8 (<1%)	19 (<1%)
Total	2,780 (100%)	1,054 (100%)	3,834 (100%)

Table 6: U.S. AIDS Cases Diagnosed Through 2007 by Race and Gender (N=1,030,832)

Race	Male N (%)	Female N (%)	Total N (%)
Caucasian	358,298 (44%)	39,034 (19%)	397,341 (39%)
African American	291,701 (36%)	120,148 (60%)	411,849 (40%)
Hispanic	155,560 (19%)	38,340 (19%)	193,900 (19%)
Other	9,477 (1%)	1,830 (1%)	11,307 (1%)
Unknown	5,001 (1%)	1,844 (1%)	6,845 (1%)
Total	820,037 (100%)	201,205 (100%)	1,030,832 (100%)*

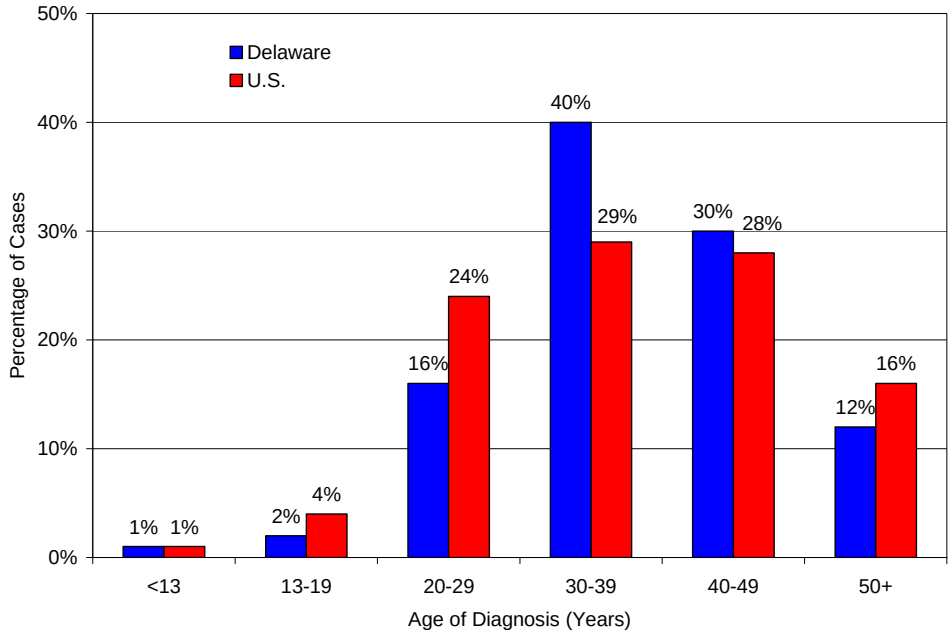
***Includes national pediatric cases = 9,590 (no breakdown available) and 4 people of unknown sex**

Unlike the African-American population, Hispanic Delawareans do not carry a disproportionate share of the state's AIDS burden. Hispanics represent approximately 6% of the state's population and account for nearly 7% of AIDS cases diagnosed in the Delaware.

Age of Diagnosis

Age of diagnosis trends among Delaware's HIV/AIDS cases are similar to those observed in the U.S. (Figure 5). At both the state and national levels, the majority of HIV/AIDS cases are diagnosed among adults age 30-39. HIV/AIDS diagnoses are less common among young children and older adults. In Delaware and the U.S., only 1% of cases are diagnosed among youth under the age of 13. Adults age 50 and older account for 12% of HIV/AIDS cases in Delaware and 16% of cases nationwide.

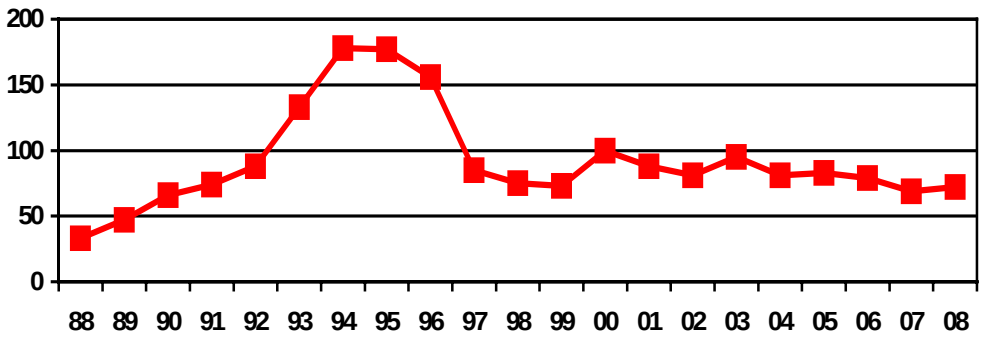
Figure 5: HIV/AIDS Cases, by Age of Diagnosis: Delaware vs. U.S., 1981-2008



Mortality

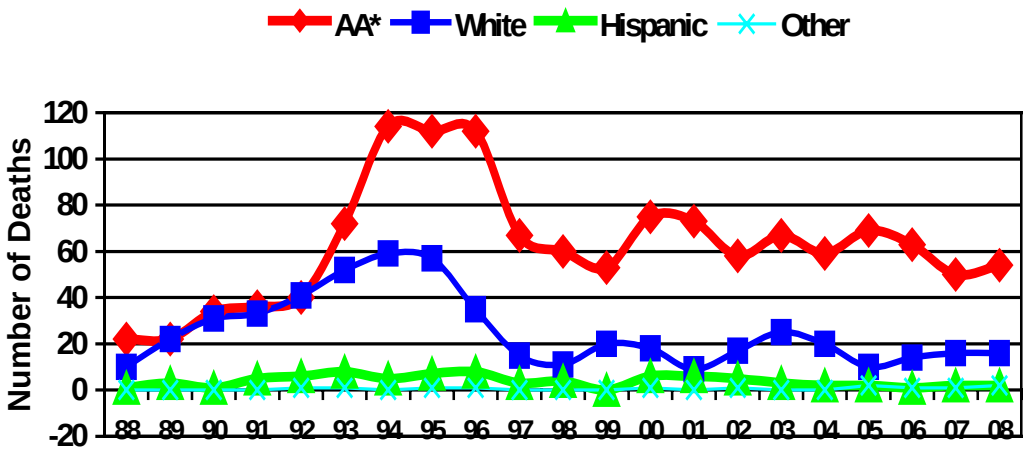
Between 1981 and 2008, a total of 2,047 Delawareans died from AIDS. The annual number of deaths due to AIDS in Delaware has declined in recent years (Figure 6).

Figure 6: Delaware AIDS Deaths, by Year: 1988-2008 (N=1,933)



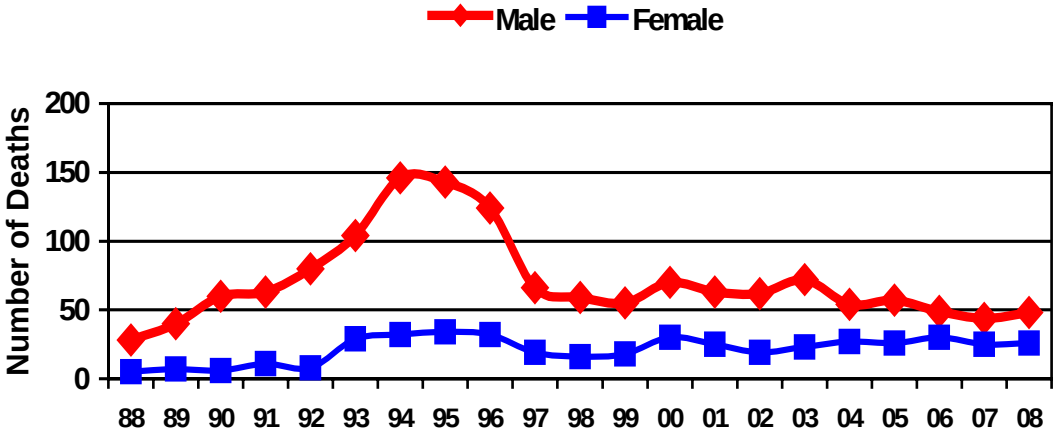
Following a peak in the early 1990s, the annual number of AIDS deaths decreased among Delawareans of all races (Figure 7). However, since 1992, the decline in the annual number of AIDS-related deaths among African-American Delawareans has been especially noteworthy.

Figure 7: Delaware AIDS Deaths by Race, 1988 to 2008 (N=1,933)



Among Delaware males, the annual number of AIDS-related deaths has declined sharply since its peak during the mid-1990s (Figure 8, below). Conversely, AIDS-related deaths among Delawarean women experienced a minor peak during the mid-1990s, and have remained fairly stable through 2008 (Figure 8).

Figure 8: Delaware AIDS Deaths by Gender, 1988 to 2008 (N=1,933)



Delaware's trends in AIDS-related deaths follow those observed at the national level. The annual number of AIDS deaths has declined among U.S. Caucasians, African- Americans, and Hispanics. On the other hand, annual AIDS-related deaths have slightly increased among the Asian/Pacific Islander and American Indian/Alaskan Native populations in the U.S. The annual number of AIDS-related deaths has declined across all geographic regions. Currently, the Northeast and South experience the highest number of AIDS deaths in the nation; the Midwest region of the U.S. continues to experience the fewest AIDS-related deaths. Behavioral surveillance data also indicate that the number of annual AIDS-related deaths continue to decline among men who have sex with men (MSM) and intravenous drug users (IDU).

Factors contributing to this decline include earlier diagnosis of HIV/AIDS, progress in the medical management of HIV, and the introduction of highly active anti-retroviral therapy (HAART). As survival rates increase for persons living with HIV/AIDS, society will face increased costs associated with chronic disease management.

3. Mode of Disease Transmission

Transmission Category Hierarchy

In an effort to monitor disease transmission trends, newly diagnosed HIV/AIDS cases are assigned to a category in the CDC-established HIV transmission risk hierarchy, shown below. Case assignment indicates the risk factor most likely to have been responsible for HIV transmission. If a newly diagnosed case reports more than one suspected mode of HIV transmission, the case is classified using the highest risk category in the hierarchy. The one exception to this rule involves males with a history of both sexual contact with other men and injecting drugs; these individuals comprise a separate exposure category (Risk Category 3).

1. Men who have sex with men
2. Injecting drug user
3. Men who have sex with men and inject drugs
4. Heterosexual contact "sex partner at risk"
    a. Sexual contact with an injecting drug user
    b. Sexual contact with a bisexual male
    c. Sexual contact with a person with hemophilia
    d. Sexual contact with a transfusion recipient with HIV
    e. Sexual contact with a transplant recipient with HIV
    f. Sexual contact with a person with HIV/AIDS; with a risk unspecified
5. Transfusion of blood/blood components
6. Transplant of tissue/organs or artificial insemination
7. Worked in a health care or laboratory setting

A relatively sizeable proportion of HIV/AIDS cases are unable to be assigned to an exposure risk category; these cases are referred to as "no identified risk" (NIR) cases. In the U.S., 25% of HIV cases and 11% of AIDS cases reported from 1981-2007 were classified as NIR cases. The NIR category generally includes cases for which the reporting source does not have the risk information to report. For example, private laboratories and blood banks generally do not have data pertaining to individuals' risk behaviors. Even hospital-reported HIV/AIDS cases may lack risk factor data; occasionally, lab tests are completed during inpatient hospitalizations and results arrive after patient discharge.

The CDC-established standard for case assignment to a transmission risk category is 85%. That is, according to CDC guidelines, no more than 15% of HIV/AIDS cases should be classified as NIR. Surveillance personnel in Delaware place a high priority on case assignment to the appropriate transmission risk category. Among all cases ever diagnosed in Delaware, only 5.6% and 2.0% of HIV and AIDS cases, respectively, are classified as NIR.

Mode of HIV Transmission:

The mode of HIV transmission within a population reflects individuals' behavioral risk factors. Interestingly, patterns of disease transmission shift over time. In Delaware, mode of HIV transmission at the beginning of the HIV/AIDS epidemic (1981-1995) differs from patterns of disease transmission over the past decade (Table 7).

From 1996-2008, the percentage of newly diagnosed HIV/AIDS cases attributable to injection drug use (IDU) dropped substantially. From 1981-1995, nearly one-half of all HIV/AIDS cases diagnosed among Delawareans were attributable to IDU. However, since 1996, the percentage of cases attributable to IDU fell to less than one-third. The proportion of Delaware's HIV/AIDS cases diagnosed among men who have sex with men (MSM) dropped from 33% to 27% between 1981-1995 and 1996-2008, respectively.

In Delaware, the percentage of cases attributable to heterosexual contact with a person who has HIV/AIDS substantially increased between 1981-1995 and 1996-2008. Occasionally, cases attributable to heterosexual contact with a person who has HIV/AIDS are later re-assigned to a different risk category if it is determined that the sexual partner who has HIV/AIDS is also an IDU and/or a bisexual. Cases attributable to other modes of transmission include pediatric cases infected via perinatal exposure, transfusion recipients, and those infected from working in a healthcare or laboratory setting. Cases representing other modes of transmission continue to account for a very small percentage of all HIV/AIDS cases in the state.

Figure 9: Delaware HIV/AIDS Cases, by Mode of Transmission: 1981-2008

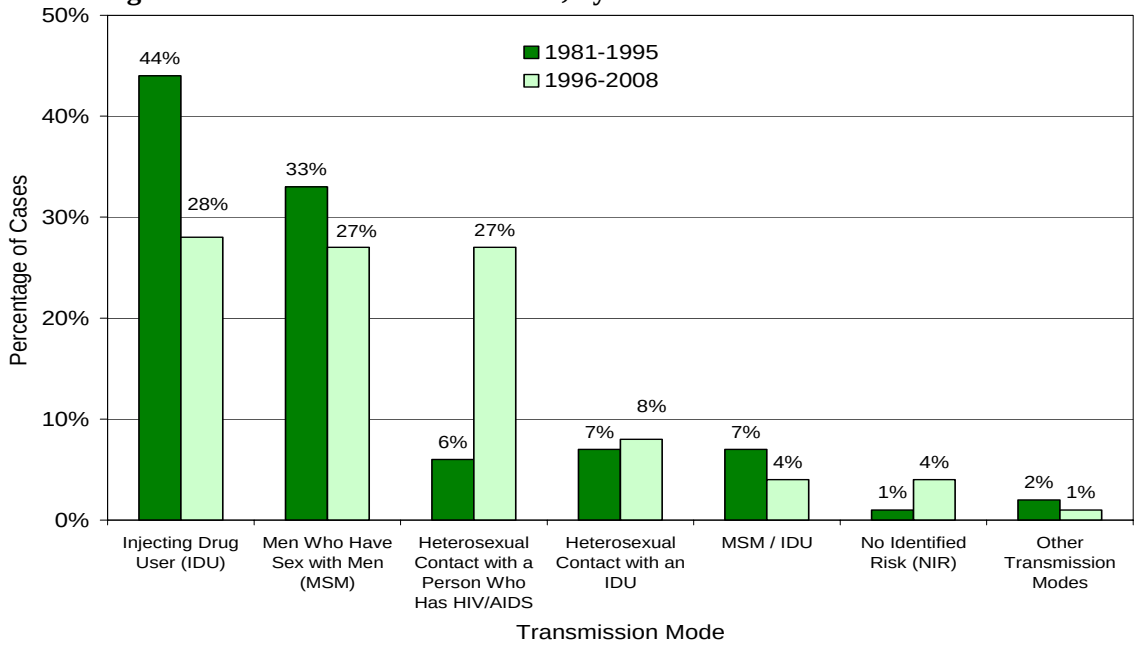


Table 7: Delaware HIV/AIDS Cases, by Mode of Transmission: 1981-2008

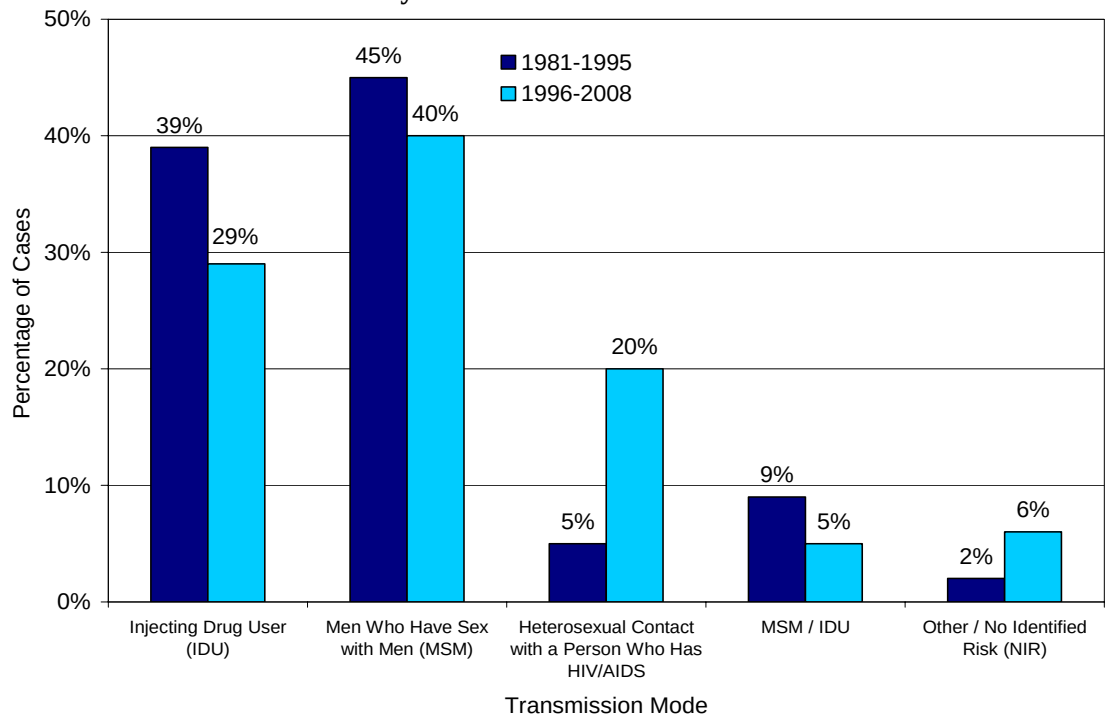
	1981-1995 N (%)	1996-2008 N (%)	Total (1981-2008) N (%)
Mode of Transmission			
Injection Drug Use (IDU)	1,040 (44%)	765 (28%)	1,805 (35%)
Men Who have Sex with Men (MSM)	784 (33%)	745 (27%)	1,529 (30%)
Heterosexual contact with PWH/A	134 (6%)	755 (27%)	889 (17%)
Heterosexual contact with an IDU	175 (7%)	234 (8%)	409 (8%)
IDU and are MSM	160 (7%)	98 (4%)	258 (5%)
No Identified Risk (NIR)	22 (1%)	121 (4%)	143 (3%)
Other Modes	43 (12%)	36 (1%)	79 (2%)
Totals	2,358 (100%)	2,754 (100%)	5,112 (100%)

Historical trends in the mode of HIV transmission among Delawareans differ by gender. Gender-specific modes of HIV transmission are explored below in more detail.

HIV Transmission among Delawarean Males

Between 1981-1995 and 1996-2008, the percentage of male HIV/AIDS cases attributable to IDU, MSM, and MSM/IDU declined in Delaware. As shown in figure 10 (next page), IDU-attributable cases among males fell from 39% from 1981-1995 to 29% from 1996-2008. Similarly, between these two time periods, MSM-attributable cases fell from 45% to 40% and MSM/IDU-attributable cases fell from 9% to 5%. In Delaware, the percentage of male HIV/AIDS cases attributable to heterosexual contact has sharply increased in recent years. From 1981-1995, heterosexual contact with an HIV-positive female accounted for just 5% of cases. From 1996-2008, 20% of all male HIV/AIDS cases were attributable to heterosexual contacted with an infected individual.

Figure 10: Delaware HIV/AIDS Cases among Males, by Mode of Transmission: 1981-2008



HIV/AIDS cases attributable to different modes of transmission (i.e., IDU, MSM, MSM/IDU, and heterosexual contact) often differ demographically. Below, the subpopulation of Delawarean men diagnosed with HIV/AIDS is explored in detail, by mode of disease transmission.

Men Who Have Sex with Men (MSM). Since 1981, a total of 1,529 MSM-attributable cases have been diagnosed among males in Delaware. MSM cases account for 42% of all HIV/AIDS cases ever diagnosed among males in Delaware. The majority (66%) of MSM cases were diagnosed in New Castle County. Kent and Sussex Counties accounted for 10% and 24% of MSM-attributable cases, respectively.

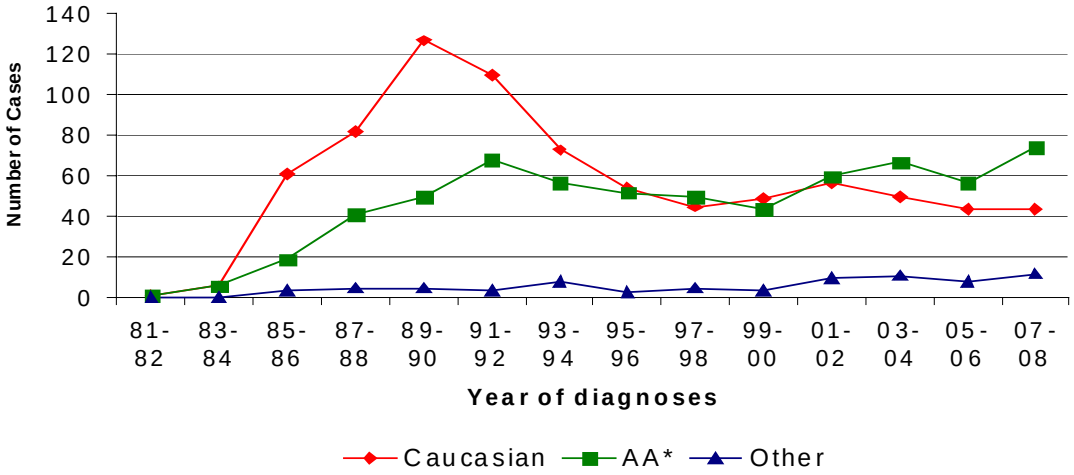
As shown in Table 8 (next page), the demographic composition of HIV/AIDS cases attributable to MSM has shifted since the early 1980s. From 1981-1995, 62% of MSM-related cases in Delaware were diagnosed among Caucasian men. From 1996-2008, the percentage of Caucasian MSM-related cases had fallen to 42%. Conversely, the percentage of MSM-attributable cases diagnosed among African-American males increased from 34% from 1981-1995 to 51% from 1996-2008. The proportion of MSM-related cases among Hispanic Delawareans has remained fairly stable since 1981. In terms of age of diagnosis, the majority of MSM-related cases were diagnosed among men ages 20-29 and 30-39.

Table 8: Delaware HIV/AIDS Cases Attributable to MSM, by Race and Age: 1981-2008

	1981-1995 N (%)	1996-2008 N (%)	Total (1981-2008) N (%)
Total Cases	784	745	1,529
Race			
Caucasian	489 (62%)	314 (42%)	803 (53%)
African-American	266 (34%)	378 (51%)	644 (42%)
Hispanic/Other	29 (4%)	53 (7%)	82 (5%)
Age Group (Years)			
13-19	6 (1%)	27 (4%)	33 (2%)
20-29	256 (33%)	194 (26%)	450 (29%)
30-39	327 (42%)	266 (36%)	593 (39%)
40-49	128 (16%)	179 (24%)	307 (20%)
50+	67 (9%)	79 (11%)	146 (10%)

As shown below in Figure 11, the number of MSM-attributable HIV/AIDS cases diagnosed among Caucasian males in Delaware peaked in the late 1980s but has declined fairly steadily over the past two decades. Conversely, the number of MSM-attributable cases among African Americans in Delaware has generally increased over time.

Figure 11: Delaware HIV/AIDS Cases Attributable to MSM, by Race: 1981-2008



Male Injecting Drug Users (IDU). From 1981-2008, 1,228 IDU-attributable cases of HIV/AIDS were diagnosed among Delawarean males. IDU-attributable cases account for 34% of all cases ever diagnosed among Delawarean men. Eighty-six percent of all male IDU-attributable cases were diagnosed among New Castle County residents; Kent and Sussex Counties account for 6% and 8% of IDU-attributable cases among males, respectively.

The vast majority (81%) of all IDU-attributable cases among Delawarean men were diagnosed within the African-American population. The percentage of IDU-attributable cases among African-Americans has remained stable since the early 1980s. The percentage of IDU cases among Caucasian males increased from 10% from 1981-1995 to 14% from 1996-2008. During the same time period, the number of IDU-attributable HIV/AIDS cases among Hispanic males decreased from 9% to 6%.

Of particular note is the substantial decline in the percentage of IDU-attributable cases among young adult Delawarean males. Between 1981-1995 and 1996-2008, the percentage of IDU cases diagnosed

among males ages 20-29 and 30-39 fell 14 and 24 percentage points, respectively. During the same time period, the percentage of IDU cases among Delawarean males age 40-49 and 50 and older increased 26 and 13 percentage points, respectively.

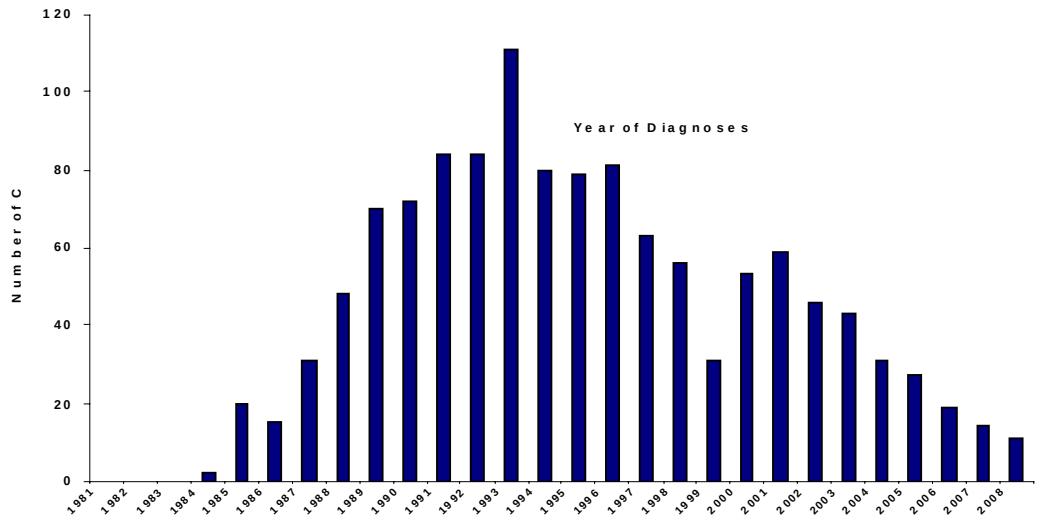
Table 9: Delaware HIV/AIDS Cases Among Delawarean Males, Attributable to IDU, by Race and Age: 1981-2008

	1981-1995 N (%)	1996-2008 N (%)	Total (1981-2008) N (%)
Total Cases	694	534	1,228
Race			
Caucasian	73 (10%)	74 (14%)	147 (12%)
African-American	562 (81%)	428 (80%)	990 (81%)
Hispanic/Other	59 (9%)	32 (6%)	91 (7%)
Age Group (Years)			
13-19	0 (0%)	1 (<1%)	1 (< 1%)
20-29	135 (19%)	27 (5%)	162 (13%)
30-39	360 (52%)	147 (28%)	507 (41%)
40-49	162 (23%)	263 (49%)	425 (35%)
50+	37 (5%)	96 (18%)	133 (11%)

As shown in Figure 12, the annual number of IDU-attributable cases diagnosed among Delawarean men has declined fairly steadily since the mid 1990s. The peak in male IDU cases that occurred in 1993 largely reflects the expansion of the AIDS definition in that same year.

It is likely that the sub-population of male IDUs in Delaware that has not yet adopted safer injection and sexual practices has reached near complete saturation in terms of HIV/AIDS. That is, the annual number of newly diagnosed IDU-attributable cases among males will likely reflect the rate by which new male IDUs join the population and fail to adopt safer injection practices.

Figure 12: Delaware HIV/AIDS Cases Among Delawarean Males, Attributable to IDU, by Year of Diagnosis and Age: 1981-2008



Men Who Have Sex with Men and Who Also Inject Drugs (MSM/IDU). Since 1981, 258 MSM/IDU-attributable cases of HIV/AIDS have been diagnosed among Delawarean men. MSM/IDU cases account for 7% of all male HIV/AIDS cases ever diagnosed in the state. The majority of MSM/IDU cases (79%)

were diagnosed among males in New Castle County; Kent and Sussex Counties account for 8% and 12% of MSM/IDU cases, respectively.

Approximately two-thirds of all MSM/IDU cases were diagnosed among African-American males. Caucasian males account for 30% of MSM/IDU cases ever diagnosed in the state. From 1981-1995 to 1996-2008, the overall number of MSM/IDU cases declined approximately 39%. Despite this decrease in the overall number of MSM/IDU-attributable cases over the past 12 years, African-American males continue to account for the majority of such cases.

From 1981-1995, 53% of all MSM/IDU cases were diagnosed among males age 30-39. However, from 1996-2008, the age group accounting for the largest percentage of MSM/IDU cases (43%) were males age 40-49.

Table 10: Delaware HIV/AIDS Cases Attributable to MSM Who Are Also IDU, by Year of Diagnosis and Age: 1981-2008

	1981-1995 N (%)	1996-2008 N (%)	Total (1981-2008) N (%)
Total Cases	160	98	258
Race			
Caucasian	48 (30%)	30 (31%)	78 (30%)
African-American	103 (64%)	65 (66%)	168 (65%)
Hispanic/Other	9 (6%)	3 (3%)	12 (5%)
Age Group (Years)			
13-19	2 (1%)	0 (0%)	2 (< 1%)
20-29	44 (28%)	9 (9%)	53 (21%)
30-39	84 (53%)	37 (38%)	121 (47%)
40-49	27 (17%)	42 (43%)	69 (27%)
50+	3 (2%)	10 (10%)	13 (5%)

Heterosexual Transmission among Males. Heterosexual transmission accounted for 453 HIV/AIDS cases diagnosed among Delawarean males since 1981. Approximately 13% of all HIV/AIDS cases ever diagnosed among Delawarean men are attributable to heterosexual contact with an HIV-positive partner. Just over 70% of male cases attributable to heterosexual transmission were diagnosed among New Castle County males. Sussex County males accounted for 18% of all HIV/AIDS cases attributable to heterosexual transmission. The remaining 11% of male cases due to heterosexual transmission were diagnosed among Kent County males.

From 1981-1995, 86 male cases of HIV/AIDS were attributable to heterosexual contact. From 1996-2008, this number ballooned to 367, reflecting a 327% increase in the number of male cases attributable to heterosexual transmission. African-American males continue to account for approximately three-quarters of cases contracted through heterosexual transmission. The percentage of male cases attributable to heterosexual contact slightly decreased among Caucasian males and slightly increased among Hispanic males between the two time periods. The relatively low percentage of cases due to heterosexual transmission among Hispanic males may partially reflect an inadequate level of HIV outreach and testing efforts in this community.

The percentage of male cases attributable to heterosexual contact has decreased substantially among males age 20-29, falling from 29% from 1981-1995 to 12% from 1996-2008. During the same time periods, the percentage of cases attributable to heterosexual transmission increased dramatically among males age 40-49 and 50 and older.

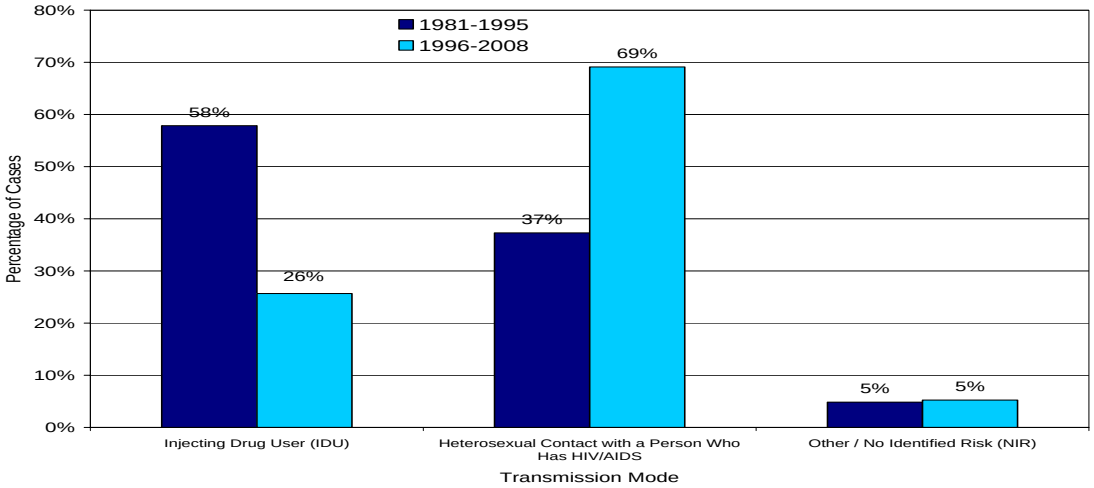
Table 11: Delaware HIV/AIDS Cases among Males, Attributable to Heterosexual Contact, by Year of Diagnosis and Age: 1981-2008

	1981-1995 N (%)	1996-2008 N (%)	Total (1981-2008) N (%)
Total Cases	86	367	453
Race			
Caucasian	20 (23%)	57 (16%)	77 (17%)
African-American	62 (72%)	274 (75%)	336 (74%)
Hispanic/Other	4 (5%)	36 (10%)	40 (9%)
Age Group (Years)			
13-19	0 (0%)	8 (2%)	8 (2%)
20-29	25 (29%)	45 (12%)	70 (15%)
30-39	32 (37%)	112 (31%)	144 (32%)
40-49	16 (19%)	116 (32%)	132 (29%)
50+	13 (15%)	86 (23%)	99 (22%)

HIV Transmission Mode among Delawarean Females

Between 1981-1995 and 1996-2008, the percentage of female HIV/AIDS cases attributable to IDU declined in Delaware. As shown in figure 13 below, IDU-attributable cases among females fell from 58% from 1981-1995 to 26% from 1996-2008. In Delaware, the percentage of female HIV/AIDS cases attributable to heterosexual contact has sharply increased in recent years. From 1981-1995, heterosexual contact with an HIV-positive male accounted for 37% of cases. From 1996-2008, 69% of all female HIV/AIDS cases were attributable to heterosexual contact with an infected individual.

Figure 13: Delaware HIV/AIDS Cases among Females, by Mode of Transmission: 1981-2008.



Female Injecting Drug Users (IDUs). Since 1981, 577 IDU-attributable cases of HIV/AIDS have been diagnosed among Delawarean females. IDU-attributable cases account for 39% of all HIV/AIDS cases ever diagnosed among Delawarean women. Eighty-nine percent of female IDU-attributable cases were diagnosed among female residents in New Castle County. Kent and Sussex Counties accounted for 6% and 5% of IDU-attributable cases among females, respectively.

From 1981-1995 to 1996-2008, the number of IDU-attributable cases diagnosed among Delaware women fell 33%. While the percentage of IDU-attributable cases among African-American females fell from 82% from 1981-1995 to 74% from 1996-2008, this population continues to account for the majority of such

cases in the state. Caucasian females accounted for 14% and 19% of IDU-attributable cases from 1981-1995 and 1996-2008, respectively. Since 1981, Hispanic females have only accounted for 5% of IDU-attributable HIV/AIDS cases in Delaware.

The percentage of IDU-attributable cases among females age 20-29 sharply declined from 34% from 1981-1995 to 10% from 1996-2008. During the same time period, the percentage of IDU-attributable cases increased among Delawarean females age 40-49 and 50 and older.

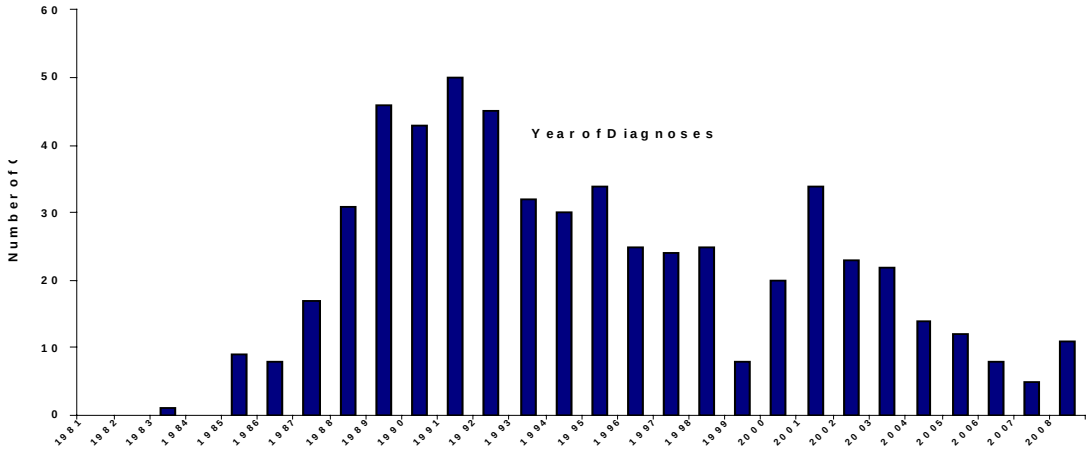
Table 12: Delaware HIV/AIDS Cases Among Delawarean Females, Attributable to IDU, by Race and Age: 1981-2008

	1981-1995 N (%)	1996-2008 N (%)	Total (1981-2008) N (%)
Total Cases	346	231	577
Race			
Caucasian	48 (14%)	45 (19%)	93 (16%)
African-American	284 (82%)	172 (74%)	456 (79%)
Hispanic/Other	14 (4%)	14 (6%)	28 (5%)
Age Group (Years)			
13-19	7 (2%)	7 (3%)	14 (2%)
20-29	117 (34%)	23 (10%)	140 (24%)
30-39	172 (50%)	93 (40%)	265 (46%)
40-49	45 (13%)	83 (36%)	128 (22%)
50+	5 (1%)	25 (11%)	30 (5%)

As shown in Figure 14, the annual number of IDU-attributable cases diagnosed among Delawarean females peaked in 1991 and again in 2001. From 2001-2007, the annual number of IDU-attributable cases among females steadily declined. In 2008, the annual number of IDU-attributable cases experienced a minor increase; however, more data are necessary to determine if this minor increase is part of trend or is simply a single-year aberration.

As with males, it is likely that the sub-population of female IDUs in Delaware that has not yet adopted safer injection and sexual practices has reached near complete saturation in terms of HIV/AIDS. That is, the annual number of newly diagnosed IDU-attributable cases among females will likely reflect the rate by which new female IDUs join the population and fail to adopt safer injection practices.

Figure 14: Delaware HIV/AIDS Cases Among Delawarean Females, Attributable to IDU, by Year of Diagnosis and Age: 1981-2008



Heterosexual Transmission among Females. Heterosexual transmission accounted for 845 HIV/AIDS cases diagnosed among Delawarean females since 1981. Among all HIV/AIDS cases ever diagnosed among Delawarean women, 56% were attributable to heterosexual HIV transmission. New Castle County females account for 73% of heterosexual transmission cases diagnosed among Delawarean women. Kent and Sussex County females accounted for 13% and 14% of all female HIV/AIDS cases attributable to heterosexual transmission, respectively.

Table 13: Delaware HIV/AIDS Cases among Females, Attributable to Heterosexual Contact, by Race and Age: 1981-2008

	1981-1995 N (%)	1996-2008 N (%)	Total (1981-2008) N (%)
Total Cases	223	622	845
Race			
Caucasian	51 (23%)	104 (17%)	155 (18%)
African-American	154 (69%)	486 (78%)	640 (76%)
Hispanic/Other	18 (8%)	32 (5%)	50 (6%)
Age Group (Years)			
13-19	17 (8%)	31 (5%)	48 (6%)
20-29	81 (36%)	149 (24%)	230 (27%)
30-39	85 (38%)	199 (32%)	284 (34%)
40-49	28 (13%)	167 (27%)	195 (23%)
50+	12 (5%)	76 (12%)	88 (10%)

4. Pediatric HIV/AIDS Cases in Delaware

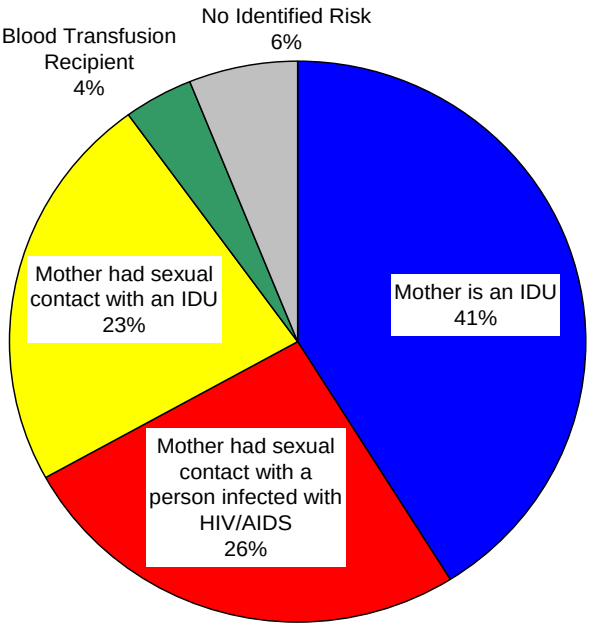
From 1981-2008, 53 children under the age of 13 were diagnosed with HIV/AIDS and 10 children died from the disease. In 2007, Delaware ranked 2nd among all states in terms of pediatric HIV/AIDS prevalence rates. In that year, Delaware's pediatric HIV/AIDS prevalence rate was 229% greater than that of the U.S. (5.6 per 100,000 vs. 1.7 per 100,000, respectively).

The majority (75%) of pediatric HIV/AIDS cases in Delaware were diagnosed among African-American youth. Caucasian and Hispanic youth accounted for 15% and 8% of pediatric HIV/AIDS cases, respectively.

Seventy-five percent of pediatric HIV/AIDS cases were diagnosed among youth in New Castle County. Kent and Sussex County youth accounted for 15% and 10% of pediatric HIV/AIDS cases, respectively.

In terms of HIV transmission, perinatal exposure accounts for 90% of pediatric HIV/AIDS cases ever diagnosed in the state. Forty-one percent of pediatric cases contracted the disease from mothers who were IDU. An additional 26% of pediatric cases contracted the disease from mothers who had sexual contact with a person infected with HIV/AIDS. Another 23% of pediatric cases contracted the disease from mothers who had sexual contact with an IDU. Four percent of pediatric cases contracted the disease through blood transfusions.

Figure 15: Delaware Pediatric HIV/AIDS Cases, by Mode of Transmission: 1981-2008



5. HIV Counseling and Testing in Delaware

From January 1, 2007 through December 31, 2008, over 30,000 Delawareans received HIV counseling services at one of the state's 45 counseling and testing agencies who run 94 individual sites. During the same two-year time period, 27,769 HIV tests were performed among Delaware residents. Of all HIV tests performed in Delaware between 2007 and 2008, 165 (0.59%) were found to be positive.

As shown in Table 14 (next page), females accounted for 52% of all Delawareans who received counseling services, as well as 52% of all HIV tests performed from 2007-2008. However, females accounted for just 25% of all positive HIV tests during the two-year period.

Slightly less than 50% of all those seeking HIV counseling and testing services were African-American. African-Americans accounted for 68% of all positive HIV tests performed in Delaware from 2007-2008. Caucasians accounted for slightly more than one-third of all Delawareans receiving HIV counseling and testing services; however, they accounted for just over one-fifth of all positive HIV diagnoses.

Delawareans age 20-29 were most likely to obtain HIV counseling and testing services; 44% of all those receiving HIV counseling and 45% of all those tested for HIV were age 20-29. However, Delawareans age 40-49 represented the age group with the largest percentage of HIV positive tests; residents in this age group accounted for 36% of all positive HIV tests diagnosed from 2007-2008.

In terms of transmission risk categories, the largest percentage of Delawareans seeking HIV counseling and testing services included those at risk for the disease through heterosexual contact only. Among this sub-population, just 0.58% of individuals tested were found to be HIV-positive. Interestingly, individuals

typically considered at comparatively higher risk for the disease (e.g., heterosexual contact + IDU, sexual contact with a person at risk for HIV/AIDS, sexual contact with a person with HIV/AIDS, MSM, and MSM/IDU) accounted for smaller percentages of Delawareans seeking HIV counseling and testing. The MSM/IDU sub-population had the largest percentage of positive HIV tests from 2007-2008. During this time period, nearly 5% of MSM/IDU individuals who were tested for HIV were found to be positive. It is also important to note that nearly 25% of all those who received HIV counseling and testing services did not acknowledge any transmission risks.

Table 14: Utilization of State HIV Counseling and Testing Services in Delaware, 2007-2008

	Delawareans Counseled (N)	HIV Tests Performed in Delaware (N)	Positive HIV Tests (N)	Positive HIV Tests (%)
Total	**30,028**	**27,769**	**165**	**0.59%**
Gender				
Male	14,479 (48%)	13348 (48%)	123 (75%)	0.92%
Female	15,544 (52%)	14416 (52%)	42 (25%)	0.29%
Not specified	5 (< 1%)	5 (< 1%)	0 (< 1%)	0.00%
Race/Ethnicity				
Caucasian	10,577 (35%)	10050 (36%)	37 (22%)	0.37%
African-American	14,332 (48%)	12,991 (47%)	113 (68%)	0.87%
Hispanic	4,513 (15%)	4,265 (15%)	15 (9%)	0.35%
Asian/Pacific Islander	264 (1%)	185 (1%)	0	0.00%
Am Indian/AK Native	57 (< 1%)	55 (< 1%)	0	0.00%
Other / Not Specified	285 (1%)	223 (1%)	0	0.00%
Age Groups (Years)				
<13	35 (< 1%)	35 (< 1%)	0	0.00%
13 – 19	3,469 (12%)	3,307 (12%)	9 (5%)	0.27%
20 – 29	13,346 (44%)	12,125 (44%)	45 (27%)	0.36%
30 – 39	6,089 (20%)	5,743 (21%)	36 (22%)	0.65%
40 – 49	4,167 (14%)	3,812 (14%)	59 (36%)	1.58%
50+	2,419 (8%)	2,317 (8%)	16 (10%)	0.80%
Age Not Specified	503 (2%)	430 (1%)	0	0.00%
Transmission Risk Category				
Heterosexual Transmission, No Other Risk	9,936 (33%)	9252 (33%)	54 (33%)	0.58%
Sexual Transmission with a Partner at Risk for HIV/AIDS	4705 (16%)	4445 (16%)	7 (4%)	0.16%
MSM	2,122 (7%)	1,624 (6%)	46 (28%)	2.83%
Heterosexual Transmission + IDU	2,010 (7%)	1,773 (6%)	17 (10%)	0.96%
Sexual Transmission with an HIV-positive Partner	596 (2%)	596 (2%)	19 (12%)	3.19%
MSM/IDU	82 (< 1%)	82 (< 1%)	4 (2%)	4.88%
No Acknowledged Risk	7,073 (23%)	6,700 (24%)	18 (11%)	0.27%
Other	3,504 (12%)	3,297 (12%)	0	0.00%

As shown in Figure 16, the number of Delawareans receiving HIV counseling and testing services has substantially increased in recent years. In 1998, 11,713 Delawareans received HIV counseling and 10,428 were tested for HIV. By 2008, these figures had increased 26% and 30%, respectively, to 14,728 and 13,531 Delawareans.

Figure 16: Annual Number of Delawareans Receiving HIV Counseling and Testing Services, 1998-2008

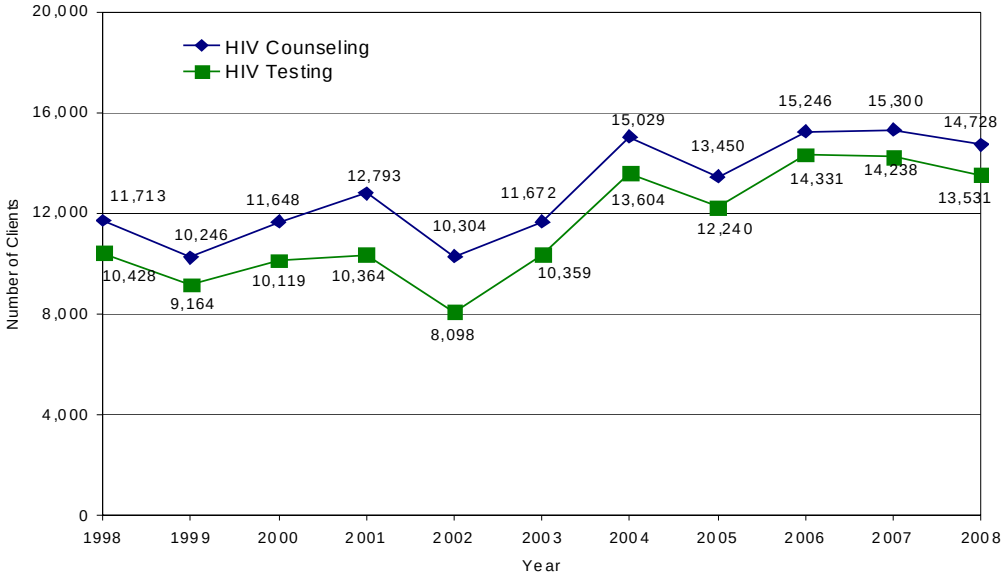
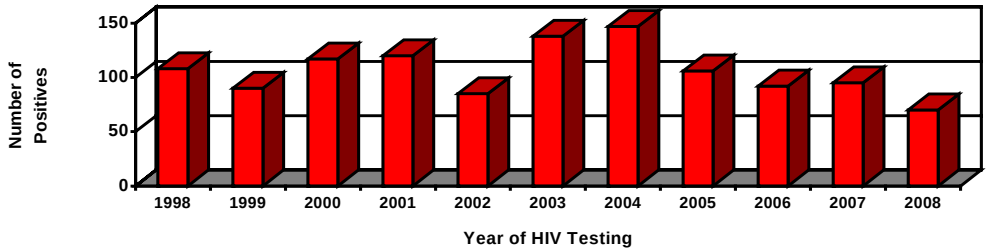


Figure 17, below, shows the annual number of positive HIV tests diagnosed among Delawareans since 1998. In 2003 and 2004, the annual number of positive HIV tests peaked among Delawareans. Since then, the annual number of positive HIV tests has trended downward. Future data will assist in confirming this pattern of positive diagnoses statewide.

Figure 17: Annual Number of Positive HIV Tests Diagnosed among Delawareans: 1998-2008



6. Utilization Patterns of HIV Services among Delawareans

To investigate utilization patterns of HIV Services across the state, DPH largely relies on data compiled by the Health Resources and Service Administration (HRSA). Delaware grantees who receive funding through multiple title programs submit data to HRSA for national-level HIV/AIDS surveillance purposes.

One such title program is the Ryan White HIV/AIDS Program. Ryan White funding is awarded to grantees for the purposes of improving the quality, availability, and coordination of healthcare and support services for individuals and families affected by HIV/AIDS. Ryan White funding also facilitates access to recommended pharmaceuticals via the AIDS Drug Assistance Program (ADAP).

In 2007 and 2008 combined, a total of 1,372 clients received services funded through Ryan White funding. Table 15, compares the demographic characteristics of the unduplicated HIV-infected clients receiving services that are funded by Ryan White HIV/AIDS Treatment Modernization Act Programs in 2007 through 2008 to the distribution of living HIV/AIDS cases in Delaware through 2008.

Table 15. Demographic characteristics of clients receiving services through Ryan White in 2007 and 2008 compared to Delaware living HIV/AIDS cases

Demographics	Ryan White 2007-2008 N(%)	Living HIV/AIDS Cases Through 2008 N(%)
Total	**1,372 (100%)**	**3,470 (100%)**
Ethnicity		
Hispanic or Latino Origin	47 (3%)	241 (7%)
Non-Hispanic	1,325 (97%)	3,229 (93%)
Unknown/Unreported Ethnicity	0 (0%)	0 (0%)
Race – (Non Hispanic)		
Caucasian (Non-Hispanic)	379 (29%)	1,011 (31%)
African American (Non-Hispanic)	919 (69%)	2,189 (68%)
Other*	26 (2%)	29 (1%)
Unknown/Unreported Race	1 (<1%)	0 (0%)
Gender		
Male	888 (65%)	2,370 (68%)
Female	480 (34%)	1,100 (32%)
Unknown/Transgender	4 (<1%)	0 (0%)
Age		
Less than 13 years	4 (<1%)	30 (1%)
13 - 19	2 (<1%)	83 (2%)
20 - 29	72 (5%)	646 (19%)
30 - 39	209 (15%)	1,298 (37%)
40 - 49	560 (41%)	1,037 (30%)
50+	525 (38%)	376 (11%)
Unknown/Unreported	0 (0%)	0 (0%)

***Other includes Asian, American Indian, and Multi-racial**

Table 16. Demographic characteristics of clients served in 2007-2008 AIDS Drug Assistance Program (ADAP) compared to living Delaware HIV/AIDS reported cases through 2008

Client Characteristics	ADAP 2007-2008 N(%)	Living with HIV/AIDS Through 2008 N(%)
Total	**934 (100%)**	**3,470 (100%)**
Gender		
Male	615 (66%)	2,370 (68%)
Female	317 (34%)	1,100 (32%)
Unknown/Trans	2 (0%)	0 (0%)
Ethnicity		
Hispanic/Latino	37 (4%)	200 (6%)
Non-Hispanic or Latino	897 (96%)	3,270 (94%)
Race		
Caucasian	280 (30%)	1,011 (29%)
African American	608 (65%)	2,189 (63%)
Other/Unknown	46 (5%)	270 (8%)
Age (Years)		
0-19	5 (1%)	113 (3%)
20-29	64 (7%)	646 (19%)
30-39	159 (17%)	1,298 (37%)
40-49	378 (40%)	1,037 (30%)
50+	328 (35%)	376 (11%)

In Delaware, Ryan White Treatment Modernization Act funding was awarded to the following three provider types:

A. Hospital-Based Clinics
    1. A.I. DuPont Hospital for Children
    2. Infectious Disease Wellness Clinics (IDWC) jointly sponsored by Christiana Care Health Services and DPH
        a. Wilmington Hospital Annex
        b. Porter State Service Center
        c. Kent Wellness
        d. Sussex Wellness

B. Community-Based Organizations (CBOs)
    1. AIDS Delaware
    2. Beautiful Gate Outreach Center
    3. Brandywine Counseling Incorporated
    4. Case Management Services
    5. Catholic Charities
    6. Central Delaware Committee on Drug and Alcohol Abuse Inc.
    7. Connections Community Support Programs Inc
    8. Delaware Center for Justice
    9. Delaware HIV Consortium
    10. Ministry of Caring
    11. Sussex County AIDS Council

C. Delaware Division of Public Health (DPH)

Ryan White funding covers a wide range of support services to residents affected by HIV/AIDS. Below is a list of services provided by Ryan White funding; in parentheses is the number of Delawareans who accessed the particular service from 2007-2008:

- Health education and case management services (929)
- Dental services (1167)
- Food-bank or home food deliveries (715)
- Direct State Services including nutritional supplements, disposable medical supplies, eye exams, and eye glasses (442)
- Emergency financial assistance (333)
- Transportation services (328)
- Housing assistance services (153)
- Health insurance services (128)
- Mental health and nutritional counseling (14)
- Durable medical supplies (6)

Infectious Disease Wellness Clinics (IDWCs) are especially important to Delawareans affected by HIV/AIDS. In 2008, IDWCs served as the main treatment location for 44% and 54% of all Delawareans living with HIV and AIDS, respectively. The majority of Delawareans with HIV/AIDS receive treatment from IDWCs regardless of county of residence.

In 2008, 1,440 Delawareans with HIV/AIDS accessed services at one of the state's IDWCs. Seventy-eight percent of those received Highly Active Antiretroviral Therapy (HAART) at an IDWC location. In

addition to treating HIV/AIDS, IDWCs perform other important wellness services including TB, STI, and Hepatitis C screening and treatment.

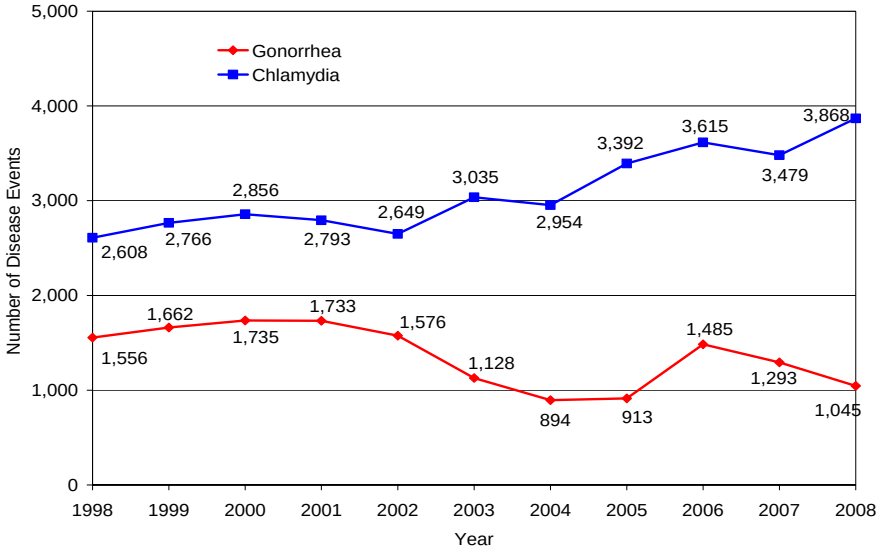
IDWCs also provide critical gynecological/obstetric care to Delaware women with HIV/AIDS. In 2008, 548 Delaware females with HIV/AIDS accessed services at one of the states IDWCs. IDWCs are equipped to perform pelvic examinations and pap tests. Of the 548 women accessing IDWC services, 22 (4%) were pregnant. Fifteen of the 22 pregnant women (68%) began receiving prenatal care in the first trimester of pregnancy. An additional 5 pregnant women began receiving prenatal care in the second trimester. All 22 pregnant women received antiretroviral medication to prevent transmission of HIV to their children. In total, 18 infants were born to the 22 pregnant HIV-positive females; none of the 18 children were HIV-positive.

7. Sexually Transmitted Infections (STIs) among Delawareans

In the field of HIV/AIDS prevention, concurrent sexually transmitted infection (STI) data are helpful for identifying populations at increased risk for transmission of the HIV virus. Like STIs, the HIV virus can also be transmitted through unprotected sexual contact. Furthermore, the presence of an STI can facilitate HIV transmission both by increasing viral load and providing ulcerations through which the HIV virus can enter the body.

In Delaware, STI data (including data related to gonorrhea, chlamydia, and primary and secondary syphilis) are collected by STI clinics, private physician offices, correctional facilities and outpatient facilities. Data are reported to the Delaware Division of Public Health (DPH). DPH compiles the data and generates statewide STI data for surveillance purposes. Individuals may be diagnosed with an STI more than once during a reporting period; recurrent cases may reflect infection recurrence and/or treatment failure. Therefore, the total number of STI cases may be greater than the total number of individuals diagnosed with an STI.

Figure 18: Annual Number of Chlamydia and Gonorrhea Disease Events among Delawareans: 1998-2008



Data from 1998-2008 indicate that Delaware's STI burden has remained fairly stable. While the annual number of gonorrhea cases diagnosed among Delawareans has declined in recent years, the annual number of chlamydia cases has sharply increased (Figure 18). In 1998, 2,608 cases of chlamydia were diagnosed statewide. In 2008, this number had increased 48% to 3,868. Chlamydia continues to be an especially salient public health problem among Delawarean females. As shown in Figure 19, female Delawareans accounted for the vast majority of chlamydia cases diagnosed each year from 1998-2008. Data from 1998-2008 also indicate no clear trend in the number of annual syphilis cases diagnosed statewide (Figure 20).

Figure 19: Annual Number Chlamydia Cases among Delawareans, by Gender: 1998-2008

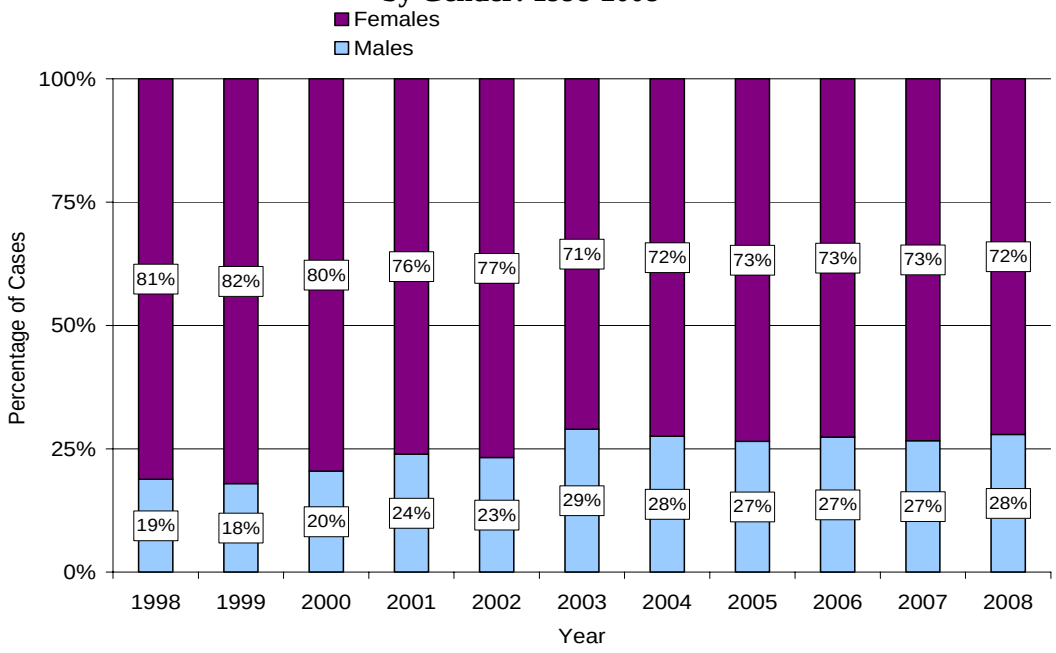
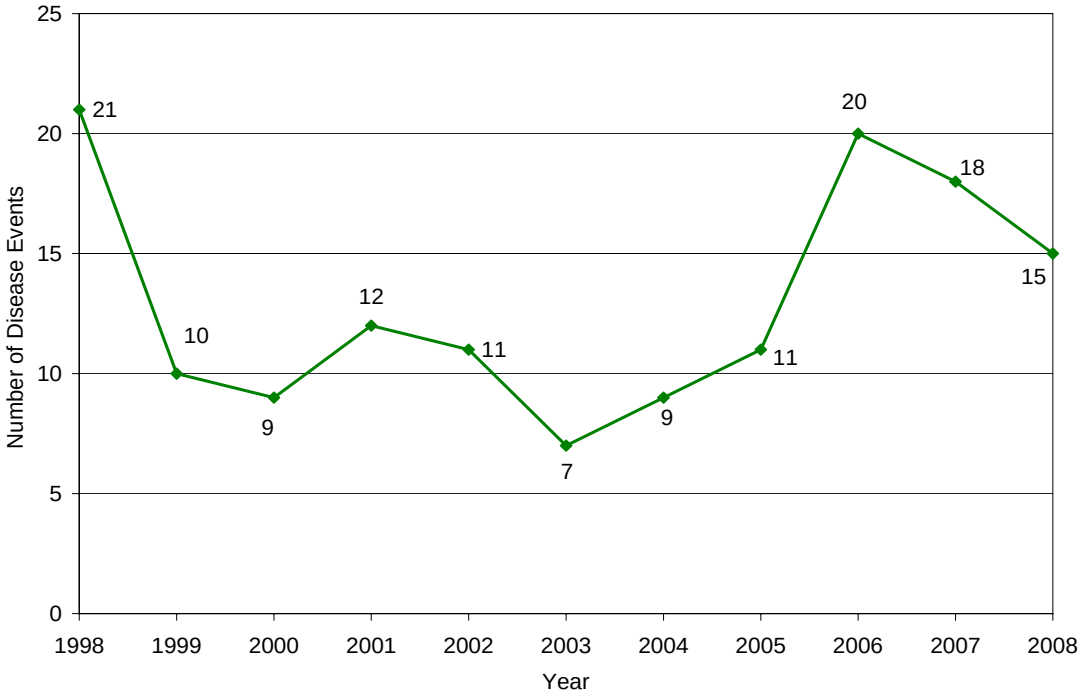


Figure 20: Annual Number Syphilis Disease Events among Delawareans: 1998-2008



8. Risk Factors among Delaware Youth

To investigate HIV/AIDS risk factor patterns among Delaware youth, DPH accessed data from the Youth Risk Behavior Survey (YRBS). YRBS represents an ongoing surveillance effort by the CDC with the overall goal of identifying risk factor trends among youth (e.g., nutrition patterns, substance use, accidents, sexual behaviors, and delinquency). These data are then used to explore the relationship between risk behaviors and health.

YRBS uses self-administered, anonymous questionnaires to collect data from high school students in odd-numbered years. The Delaware Department of Education oversees the implementation of YRBS. In 2007, a total of 2,639 Delaware youth from 38 Delaware public high schools participated in YRBS. YRBS data are representative of all Delaware students in grades 9-12.

Delaware-specific YRBS results, in terms of the percentage of Delaware youth respondents partaking in health risk behaviors, are as follows:

Alcohol Use

- 75.2% had at least one drink of alcohol in their lifetime
- 27.5% had their first drink of alcohol before age 13
- 45.3% had at least one drink of alcohol on one or more of the past 30 days
- 27.0% had five or more drinks of alcohol in a row at least once in the past 30 days

Other Drug Use

- 43.1% used marijuana at least once in their lifetime
- 10.1% tried marijuana for the first time before age 13
- 25.4% used marijuana one or more times during the past 30 days
- 6.4% used one or more forms of cocaine at least once in their lifetime
- 3.1% used one or more forms of cocaine at least once in the past 30 days
- 13.1% sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high at least once in their lifetime
- 4.1% sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high at least once during the past 30 days
- 2.2% used heroin at least once in their lifetime
- 4.0% used methamphetamines at least once in their lifetime
- 2.1% used a needle to inject any illegal drug into their body at least once in their lifetime
- 22.2% were offered, sold, or given an illegal drug on school property by someone during the past 12 months

Sexual Behaviors

- 58.1% had sexual intercourse at least once in their lifetime
- 21.4% had sexual intercourse with four or more people during their lifetime
- 43.6% had sexual intercourse with one or more people during the past three months

Of students who had sexual intercourse during the past three months:

- 22.4% drank alcohol or used drugs during last sexual intercourse
- 66.2% used a condom during last sexual intercourse
- 15.8% used birth control pills during last sexual intercourse
- 8.1% had been pregnant or gotten someone pregnant one or more times

Conclusion

Despite medical advances and disease prevention efforts, HIV/AIDS continues to have a devastating impact on the health and well-being of Delawareans. Recent EHARS data indicate that there are approximately 964 HIV-positive Delawareans who have not received care within the past 12 months. The need to reach HIV-positive Delawareans earlier in disease progression has never been more urgent. Ensuring continuous medical treatment for Delawareans with HIV/AIDS is nothing short of a life-saving

effort. Interventions must address at-risk populations and tailor intervention efforts to each population's unique cultural, economic, religious and sexual context.

It is our hope that the data contained in this report will help to prevent future cases of HIV/AIDS among Delawareans by identifying populations most at risk for the disease and tailoring HIV services accordingly.

References

1. United States Census Bureau from website: http://quickfacts.census.gov/qfd/
2. Delaware Division of Public Health, Health Statistics Center, *Delaware Vital Statistics Annual Report 2006*
3. HIV/AIDS Evaluation Reporting System (EHARS), HIV/AIDS Surveillance, DPH
4. Center for Disease Control and Prevention, *HIV/AIDS Surveillance Report 2007* Year-end edition Volume 19, U.S. HIV and AIDS cases reported through December 2007, http://www.cdc.gov/hivdhap.htm
5. Division of Public Health, Disease Prevention and Control, Counseling and Testing System Report 2008, internal document.
6. Division of Public Health, Disease Prevention and Control, HIV/STD/Hepatitis C Section, *Sexually Transmitted Disease Annual Report 2008*, internal document.
7. Department of Education, Division of Adolescent and School Health (DASH), Youth Risk Behavior Survey (YRBS), 2007 from website: http://www.cdc.gov/nccdphp/dash/yrbs/results.htm
8. Ryan White Data Reports (RDR). Health Resource and Services Administration (HRSA), 2007 and 2008.

--END OF 2008 DELAWARE HIV/AIDS SURVEILLANCE REPORT--

B. Trends/Emerging Trends:

1. **Epi Update:** The following epidemiological information—updated in March 2008 and May 2009—was presented to the Planning Council membership at its regular meetings:

   Gender
   - Males are 49% of Delaware's population, yet 71% of new infections through 2008.
   - Females are 51% of Delaware's population, yet 33% of new infections from 2000 to 2008 and 41% in the last two year, compared to 20% of new infections through the late 1980s.

   Ethnicity
   - Despite being only 21% of Delaware's population, Delaware's African Americans have a disproportionately high HIV/AIDS rate. While 44% of the cases were attributed to African Americans in the late 80s, that figure jumped to 66% by the end of 2008.
   - Overall, newly diagnosed infections are going down or holding steady for African Americans, per 2008 statistics.
   - Despite that good statistics, newly diagnosed infections rose sharply for African American females in 2008.

   Age
   - 70% of HIV/AIDS cases in Delaware through 2007 are within the 30-49 age group.
   - Newly diagnosed infections show an increase in 2007 in the 20-29 and 40-49 age groups.
   - Pediatric and teen infection rates remain low as compared to other states.
   - Despite the low rate, infection rates for teens and those in their 20s are on the rise.

Mortality

- Because of highly active anti-retroviral therapy and better management of the disease, people with AIDS are living longer.

Geography

- The Wilmington metropolitan area reported 66% of the New Castle County HIV/AIDS cases through 2008, while 49% of all HIV/AIDS cases reported in Delaware through 2008 originated from Wilmington Metropolitan area minority populations.
- IDUs still are the largest group living with HIV/AIDS in New Castle County over the last 11 years, but this is diminishing with a shift toward heterosexual transmission.
- MSMs are still the largest group living with HIV/AIDS in Sussex County over the last 11 years, but this is diminishing with a shift toward heterosexual transmission.

Behavioral Risk Groups

- The needle exchange program in Wilmington is working, as evidenced by an increase in the numbers of IDUs being tested and therefore showing up in the numbers of new positives.
- Heterosexual transmission has jumped significantly, as evidenced by the following statistics:

Highest risk group in cases reported through 1999	**Shifting risk population in Delaware from 2000 to 2008**
-IDU = 42% (n =1171)	-Heterosexual transmission = 36% (n = 850)
-MSM = 30% (n =844)	-MSM = 27% (n = 642)
-Heterosexual transmission = 16% (n = 445)	-IDU = 27% (n = 633)

2. **Recent New Infections of Young MSMs:** Several Planning Council Members who work in local clinics, counseling and testing sites and in the provision of Comprehensive Risk Counseling and Services made a presentation in May 2009 to the Planning Council regarding concerns about the recent number of newly-infected young clients, primarily MSMs, testing either HIV positive or as AIDS-defined. The number of HIV positive youth ages 18 to 25, as well as those AIDS-defined, had increased over numbers from the same period last year.

3. **Change in Incidence Pattern**: Despite the relative stability of the overall epidemic in Delaware over the last eight years, Delaware has been experiencing a change in the incidence pattern over the last five years. Specifically, 71% (over 2/3) of all new cases have occurred in zip codes with 20 or fewer cases per year; 32% (1/3) of incidence occurs in zip codes with five or fewer cases per year.

C. Changing Environment

Many of the environmental changes facing Delaware are similar to those that other states are facing:

- CDC HIV Prevention funds have been "flat funded" for the last three years.
- Ryan White Program funding has been steadily cut in recent years and continued cuts are anticipated through at least 2010. This reality, coupled with the fact that the program is up for reauthorization in the fall of 2009, makes it difficult to plan for sustained programming.
- Other related federal funds have been flat funded for the last several years e.g., TB, STD.
- The economic downturn may continue to have a significant impact on the availability of resources.

Chapter IV identifies prioritized populations and prevention interventions needed for those populations—along with the emerging trends that impacted their selection—in order to direct funding appropriately to reduce HIV transmission in Delaware. These populations and interventions will be continuously evaluated and updated, as needed, throughout the life of the Comprehensive Plan.

A. Building on the Past

Prevention is key to reducing the spread of HIV/AIDS, and local community members are encouraged to participate in the process of developing prevention plans that help meet the needs of their communities. Indeed, since the start of the disease, Delaware community members—from PLWHA to service providers to related community partners—have been instrumental in the process. They are guided by the Centers for Disease Control (CDC), which spearheads efforts in the United States to slow the advancement of HIV and prevent new infections. The CDC authors guidances that help focus communities and health departments on decreasing the number of persons at high risk for acquiring or transmitting HIV infection through the provision of targeted, sustained, evidence-based and theory-based HIV prevention interventions.

The last prevention plan for Delaware, the 2005-2009 Delaware Comprehensive HIV Prevention Plan (2005 Plan), was developed using an extensive community planning process informed by two of these guidance documents:

1. *Advancing HIV Prevention* initiative, geared towards increasing HIV testing, improving medical care/treatment, and reducing barriers to early HIV diagnosis; and
2. *Guidance for HIV Prevention Community Planning*

Three CPG work groups—Needs Assessment, Populations, and Interventions--followed an intensive, three-year process that produced a detailed plan that included the following elements:

- Epidemiological profile for that period
- Results of assessments and gaps analyses conducted to further examine the epidemic
- Descriptions of work group methods for systematically and scientifically prioritizing populations and recommending interventions
- An assemblage of prevention interventions and activities by populations
- Information on community member involvement

The 2005 Plan's statewide collection of population and intervention recommendations served Delaware well through 2009, as a result of the extensive planning process and the relative stability of the epidemic. [3] The 2005 Plan was reviewed, evaluated, and updated each year and the Planning Council provided a letter of concurrence in support of DPH's annual applications to the CDC for prevention funding and the updated 2005 Plan. Beginning in 2005, the Planning Council began a multi-year process to develop the next five-year plan, which integrates the treatment and prevention plans.

The Planning Council examined the 2005 Plan population recommendations in context of the most recent epidemiological information (including the 2008 Delaware HIV/AIDS Surveillance Report presented in Chapter III, monthly surveillance data, CTR data and service evaluation data) and evaluated prior recommendations in context of client and provider surveys conducted over the last five years. (The full process regarding these steps is more fully described in Sections B, C, and D of this chapter.)

[3] *A copy of the 2005-2009 HIV Prevention Plan is available from the Delaware HIV Consortium at 302-654-5471.*

Identified trends with impact on program development are as follows:

- A shifting in ordinance of Delaware's risk populations from IDU (42%), MSM (30%), and HET (16%) to HET (36%), MSM (27%), and IDU (27%).
- A sharp rise in newly diagnosed infections among African American females in 2008.
- A shift of incidence from a small number of relatively high-incidence areas to a larger number of relatively low-incidence areas.

B. Discussion of Identified Trends with Impact on Program Development

The shift in ordinance among the priority populations by percentage of all cases is significant, but it is difficult to definitively establish causality for the change. All of the populations mentioned have been priority populations in Delaware for more than a decade and the shift has occurred during a period of reduction in the overall incident rate. It seems likely that the change in precedence has occurred as a natural progression of the epidemic through at-risk populations in the order in which they entered the epidemic: 1) the populations appearing earlier in the epidemic (IDU and MSM) having achieved a level of 'saturation' in the population members most at-risk resulting in a decrease in incidence—essentially through a process of attrition; and 2) populations appearing in the epidemic later (heterosexuals and heterosexual partners of IDU) are still 'pre-saturation' and are still increasing in incidence.

The same is true of the growing equality between male and female heterosexual/IDU incidence in Delaware. Men appeared in greater numbers earlier in the epidemic (infected through IDU and MSM), and women appeared in greater numbers as the epidemic progressed (infected through sexual contact with male IDU and MSM). As the incidence among male IDU populations and MSM populations achieved zenith and decreased, the prevalence of infected men among women's sexual and needle sharing partners nonetheless increased (in part due to a fantastically successful treatment program)—preceding and predicting a rise of incidence among at-risk women.

In the context of a steady decrease in overall incidence in recent years, it also seems likely that both progressions have been successfully mediated to some extent by prevention/treatment service providers. It is essential that the program adapts to address an epidemic that continues to move toward equality of prevalence among the HET/IDU/MSM and male/female cases.

Neither of these changes are particularly unexpected–the epi-data have documented this shift in progress for several years—nor do they necessarily mandate a change in core paradigms. In fact, implementation and funding of programs, guided by the epi-data, already closely match the new affected population precedence by race and sexual orientation. The shift in geographical dispersion of HIV incidence, however, indicates a more fundamental change to programming may be necessary. Historically, Delaware's HIV epidemic has most powerfully affected New Castle County—and Wilmington in particular. This remains true when the zip codes with the highest incidence rates in Delaware are listed high to low. It must be remembered, however, that the rules governing the release of statistical data prohibit public publishing of data of any particular geographically- or demographically-defined cohort that includes five (5) or fewer cases. This can prevent an epidemic with relatively low incidence that is very geographically dispersed from being perceived in is entirety.

There are several conditions—developing over the last five to eight years—that must be given consideration in order to have a full appreciation of the epidemic across the state.

From 2004 through 2008:

1. The incidence rate has diminished from 223 to roughly 172 (a reduction in incidence of roughly 23%).
2. The zip code with the highest incidence cases in each year 2004 to 2008 had 34, 26, 23, 23, and 22 cases, respectively.
3. 71% (*over 2/3*) of all new cases have occurred in zip codes with 20 or fewer cases per year.
4. 32% (*1/3*) of incidence occurs in zip codes with five or fewer cases per year.

Simply stated, while the populations most at risk have not radically changed (though have changed order of precedence), the geographic dispersement of cases has significantly changed to reflect a greater percentage of incidence cases in smaller concentration within an increased number of rural and suburban areas throughout the state.

The changes outlined above raise several additional considerations for HIV prevention in the next five years:

1. The cluster-size for both incidence/prevalence and the general population density is too small in many areas to support cost-effective group-based interventions for positives or negatives—or even (social) community-level interventions.
2. Clearly, when a zip code with no known prevalence appears with a new incidence case, the resident has accessed a transmission network outside his/her local environment. There is virtually no information available about how, when, or where individuals from these relatively rural areas are interacting with one another or with people in areas with higher-prevalence—nor the specific mechanism used to facilitate the interaction.
3. Continued reliance on describing Delaware's epidemic by zip code is no longer sufficient to properly facilitate planning or targeting of services. This is increasingly evident as programs are successful in reducing overall incidence, and many zip codes may have very few incidence cases in coming years. It is easy to make the assumption that cases within zip codes are connected to one another, but there is no information available to indicate if any particular infection occurred as a part of a zip-contained network or if each of the infections occurred as part of a separate transmission network that extends outside the zip code.

These changes indicate a need to continue evolution of the overall program paradigm away from an educate/prevent-infection model and toward an identify/prevent-transmission model in order to continue success in reducing HIV incidence in the next five-years. Specifically:

1. Facilitating (or funding) a successful and specific CBO-based, DEBI ILI/GLI for each small cluster of cases in each geographic area is neither possible nor—even if sufficient funding existed—cost effective. Many rural areas of the state lack social/community infrastructure sufficient to even identify a venue where targeted outreach might be successful. However, 100% of households in Delaware have access to cable, satellite, or broadcast television and/or radio and/or web access and/or print media. Delaware must increase use of mass media to forward HIV prevention and, specifically, encourage use of HIV screening services—especially among rural/suburban populations unlikely to be reached through any ILI or GLI prevention intervention.

2. A greater emphasis must be given to providing on-going and consistent prevention services to infected individuals throughout the state. The program provides and must continue to provide CRCS for high-risk individuals that require intensive intervention to solve multiple and complex barriers to risk reductions, such as homelessness, joblessness, mental illness,

addiction, etc. However, there is need for more consistent, ongoing, low-intensity prevention counseling services for all HIV infected individuals to maintain risk-reduction behaviors and encourage maintenance of treatment services. A statewide mechanism to cost-effectively provide these services must be implemented.

3. The program must develop a mechanism for obtaining, maintaining and analyzing case-study level data for new HIV infection cases to accurately define infection networks and identify opportunities for network disruption. Program implementation/guidance based on high-level demographic/geographic descriptors will no longer adequately facilitate success in reducing Delaware's annual HIV incidence.

4. In order to best use available funding for DEBI interventions, service areas for contracted CBOs must not be limited/defined by zip code, but be defined by the specific information gained through case-study data and/or be sufficiently broad to allow full use of contracted time and resources when localized demand for services does not fully use capacity—for instance, placing emphasis on specifically defined target populations or network disruption, but allowing experimentation and exploration to reach those in outlying areas once core objectives have been met.

5. Greater emphasis must be given to institutionalizing prevention education and services into services and environments likely to be encountered by those that cannot/will not be reached by targeted DEBI's: the education system, school-based wellness centers, youth incarceration centers, universities and colleges, general medical practice, etc. To this end, greater emphasis must be given to achieving universal Opt-Out HIV screening in clinical settings.

The evolution of the HIV prevention paradigm in Delaware that is most likely to contribute to continued success in reducing annual HIV incidence is an approach that:

- Emphasizes mass/environmental interventions to increase the likelihood that infected individuals will learn of their HIV status by recruiting individuals to voluntary HIV screening services and making HIV screening a routine part of medical care.
- Emphasizes investigation and disruption of defined infection networks through quick and thorough case-level data collection on index clients, partner elicitation, partner notification and infection network mapping.
- Emphasizes individual, on-going, low-intensity risk reduction counseling and partner services for all HIV infected individuals not accessing more intensive CRCS.
- Emphasizes institutionalization of prevention education and screening messages whenever possible.
- Emphasizes use and coordination of CBO-based programs in venues where institutionalization of prevention services is not possible; where audiences for targeted programs are defined with detail; where disruption of specific transmission networks or environments is possible; and where cost-effective.
- Emphasizes consolidation of services and elimination of duplication of services/programs in order to maximize utilization of service capacity.

C. Updated Needs Assessment

As stated, the Planning Council began the current Comprehensive Plan in 2005. Since then, it has examined the epidemic from a statistical standpoint (primary epidemiological, surveillance). Next, it examined it from the perspective of PLWHA, providers, and the general public (information the Planning Council gathered through a series of assessments conducted over four years): the 2006 Agency Capacity and Capability Survey, the 2006 Consumer Survey, the 2008 Provider Perspective

Survey, a first-time 2008 Prevention/At-Risk Survey, and the 2008 Gaps Analysis, which compared and analyzed findings from the surveys. Additionally during the period, the Planning Council updated and re-printed the Delaware Resource Guide twice, adding Spanish interpretation throughout the 2009-2011Guide. (See pages 89 through 94 for more information on the survey assessments. As stated, copies of all surveys, complete reports and the Resource Guide are available from the Delaware HIV Consortium.)

As a part of the review process, the Planning Council utilized an assessment table set up by the former CPG Needs Assessment Work Group to highlight current need and interventions being provided. The table includes all categories of general populations ultimately recommended under the 2005 Plan (with positives and negatives not separated), as well as services provided in 2009. Information on the table is from the following sources:

- The 2008 Delaware HIV/AIDS Surveillance Report, including information from the 2007 Youth Risk Behavior Survey (YRBS)
- Delaware Monthly HIV/AIDS Report (surveillance data)
- A 2009 presentation made to the Planning Council by Planning Council members
- National Household Survey on Drug Abuse
- 2009 Prevention Funded Services

Additional information from the 2006 Agency Capacity and Capability Survey, the 2006 Consumer Survey, the 2008 Provider Perspective Survey, the 2008 Prevention/At Risk Survey, and the 2008 Gaps Analysis follows the chart.

NEEDS ASSESSMENT CHART

Populations	2009 Need	2009 Met Need (Intervention)[4]
Heterosexual	2008 Delaware HIV/AIDS Surveillance Report, Annual Epi Update, Monthly Surveillance Data: • Over the last eight years, heterosexual transmission has risen in DE from being the lowest risk group (16%) to the highest (36%). The highest risk groups have shifted in Delaware to heterosexual (36%), with MSMs and IDUs tied at 27% • 2008 Surveillance Report shows a steady rise in females with HIV/AIDS since the start of the epidemic. • 29% of DE AIDS cases are female. • Since 1995, heterosexual contact, as a mode of exposure, has increased from 6% to 27%. • 55% of females were infected through heterosexual contact. • Females represent 25% of new infections in the last two years. • Newly diagnosed infections rose sharply for African American females in 2008. • Among female heterosexuals, 35% contracted HIV through sex with an IDU partner. • From 1981-1995, 86 male cases of HIV/AIDS were attributable to heterosexual contact. From 1996-2008, the number ballooned to 367, a 327% increase. • Of DE males infected through heterosexual contact with a woman, 73% had sex with a woman with HIV. • Nearly ¾ of all heterosexual male HIV infections have occurred among African Americans. • Heterosexual transmission in the 40+ age group is increasing. • 14% of female AIDS cases in Sussex County were infected through heterosexual contact, 13% in Kent County, and 73% in New Castle County.	**Current Services:** **New Castle County** • Beautiful Gate Outreach Center (GLI, Outreach, C&T) • Each One, Teach One (GLI, Outreach, C&T) • Latin American Community Center (Outreach, C&T) **Kent County** • Kent Sussex Counseling Services (secondary) (Outreach, CTR) **Sussex County** • LaRed (Outreach, C&T) • Sussex County AIDS Council (Primary) Outreach, C&T) (until agency closed in June 2009) **Statewide** • Division of Public Health (CTRPS)
Injecting drug user/Substance abuser (IDU/SA)	2008 Delaware HIV/AIDS Surveillance Report, Annual Epi Update, Monthly Surveillance Data: • Of 453 heterosexual contacts for men, sex with a female IDU accounted for 26%. • IDUs are still the largest group living with HIV/AIDS in New Castle County over the last 11 years, but this is diminishing with a shift toward heterosexual transmission. • The Needle Exchange Program is working as evidenced by an increase in the numbers of IDUs being tested and the new positives being diagnosed. • 30% of DE AIDS cases are IDU.	**Current Services.** **New Castle County** • Brandywine Counseling, Inc. (Outreach, C&T, Needle Exchange) **Kent County** • Kent Sussex Counseling Services (primary) (Outreach, CTR)

[4] Intervention abbreviations listed in the above chart are as follows:

CRCS=Comprehensive Risk Counseling Services, formerly Prevention Case Management (PCM)
CTRPS=Counseling, Testing, Referral, Partner Services
C&T=Counseling & Testing
CTR=Counseling, Testing & Referral
HC/PI=Health Communication/Public Information
GLI =Group Level Interventions
ILI=Individual Level Interventions

NEEDS ASSESSMENT CHART

Populations	2009 Need	2009 Met Need (Intervention)[4]
Injecting drug user/Substance abuser (IDU/SA) Continued	• 23% of persons living with HIV were infected through IDU. • 14% of DE HIV/AIDS cases were infected through heterosexual contact with an IDU. • MSM/IDU are the fourth highest behavioral risk in DE's HIV/AIDS population. • 80% of IDU HIV/AIDS cases in DE have been African American. • 86% of IDU male cases and 89% of female cases reside in New Castle County. • According to the 2008 Provider Perspective Survey, providers (treatment) perceived that approximately 22% of their clients were IDUs. YRBS Responses Regarding Substance Abuse (school youth survey): • 75% of youth had at least one drink of alcohol during his/her life. • 45.3% had at least one drink or more in the past 30 days. • 43% of youth had used marijuana. • 6.4% used any form of cocaine one or more times during his/her life; • 3.1% used any form of cocaine one or more times during the past 30 days. • 2.2% used heroin one or more times. *NOTE: data does not indicate needle use or sharing behaviors.* 2008 Prevention/At Risk Survey Responses: • 10% of participants were IDUs • 7.1% of participants used alcohol or drugs before/during sex National Household Survey on Drug Abuse: Approximately 61,000 DE residents over the age of 12 used illicit drugs in 2007 *NOTE: data does not indicate needle use or sharing behaviors.*	**Sussex** • Sussex County AIDS Council (Primary) Outreach, C&T) (until agency closed in June 2009) **Statewide** • Division of Public Health (CTRPS) • Gateway Foundation (GLI, C&T)
MSM	2008 Delaware HIV/AIDS Surveillance Report, Annual Epi Update, Monthly Surveillance Data: • Currently, 31% of DE AIDS and 33% of HIV cases are MSM. • African American MSM HIV cases are increasing, while Caucasian cases are decreasing. • Through 2008, 24% of HIV/AIDS cases in Sussex County are MSM, 10% in Kent County and 66% in New Castle County. • MSMs are still the largest percentage in Sussex County over the last 11 years, but it is shifting toward heterosexuals. • 9% of DE current HIV/AIDS cases are MSM/IDU. Planning Council Presentation by Clinic and C&T Staff: • Local clinics and counseling and testing sites are seeing a rise in young African American MSM testing positive or being diagnosed initially at AIDS-defined (17 to 25) • These clients are presenting having multiple partners, unprotected sex, and "friends with benefits". • They have knowledge about risks but have a disconnect between knowledge and behaviors. • They have problems in addition to their HIV status.	**Current services**: **New Castle County** • AIDS Delaware (CRCS, Outreach, C&T) **Sussex County** • CAMP Rehoboth (ILI, CRCS, Outreach, C&T, chat room) **Statewide** • Division of Public Health (CTRPS)

NEEDS ASSESSMENT CHART

Populations	2009 Need	2009 Met Need (Intervention)[4]

Youth	2008 Delaware HIV/AIDS Surveillance Report, Annual Epi Update, Monthly Surveillance Data:
	• Pediatric and teen infection rates remain low compared to other states.
	• Although the number of persons in the 13 to 19 age group that is infected is small, there has been an increase in infections of 50% from 2007 - 2008.
	• New infections in persons 20-29 are also increasing.
	Planning Council Presentation by Clinic and C&T Staff: (repeat of comment under MSM above):
	• Local clinics and counseling and testing sites report a rise in young African American MSM testing positive or being diagnosed initially at AIDS-defined (17 to 25)
	  • These clients are presenting having multiple partners, unprotected sex, and "friends with benefits".
	  • They have knowledge about risks but still engage in risky behaviors.
	  • They have multiple social problems in addition to their HIV status.
	YRBS Responses Regarding Sexual Activity (school youth survey):
	• 58% of youth responding having had sex.
	• 21% had sex with four or more people.
	• 44% had sex during the last three months.
	• 6% used a condom in their last act of intercourse.
		Current services
		New Castle County
		• Each One, Teach One (Outreach, C&T, GLI)
		
		Statewide
		• Division of Public Health (CTRPS)

Incarcerated Who Are HIV+ and HIV-	• The HIV Prevention Program works with the State Department of Correction to provide HIV testing to inmates. • Ryan White funding is coordinated with the Department of Correction to connect released HIV positive inmates to community-based care and prevention services.	**Current Services:** Provided through the Delaware Department of Corrections
Seniors (50 and above)	2008 Delaware HIV/AIDS Surveillance Report, Annual Epi Update, Monthly Surveillance Data: • 66% of those living with HIV/AIDS are 30 to 49 years of age; only 11% are 50+. • If those testing positive from 2007-2008, 10% were 50+ and 36% were 40-49. • People with HIV/AIDS are living longer, a statistic that will impact prevention and treatment needs as the population ages.	**Current Services:** **Statewide:** • DPH (CTRPS)
Hispanics (Statewide)	2008 Delaware HIV/AIDS Surveillance Report, Annual Epi Update, Monthly Surveillance Data: • Hispanics represent 5.6% of the DE HIV/AIDS cases since the start of reporting; Hispanics represent 7% of those currently living with HIV/AIDS. • 5% of MSMS since the start of the epidemic are Hispanic/Other in DE. • 7% of HIV/AIDS IDU cases in Delaware since the start of the epidemic are Hispanic/Other. • 5% of MSM/IDU are Hispanic/Other since the start of the epidemic. • 10% of heterosexual males with HIV/AIDS over the last 12 years are Hispanic/Other, up from 5% over the prior reporting period. • 10% of heterosexual males with HIV/AIDS over the last 12 years are Hispanic/Other, up from 5% over the prior reporting period.	**Current Services:** **New Castle County** • Latin American Community Center (Latinos) (Outreach, C&T) **Sussex County** • LaRed (Latinos) (Outreach, C&T)

Additional Prevention Information from Planning Council Surveys:

The Planning Council used the four surveys that it conducted this planning cycle to gather information regarding treatment and prevention services. Additional findings not included in the preceding chart follow:

1. 2006 Agency Capacity and Capability Survey:
   This survey was completed by 59 of the agencies listed in the 2006-2008 Resource Guide. The agencies provided a variety of services, including counseling, food services, prevention with positives, education, medical and supportive services. Responses included the following:

   - Staff needed training on several topics: knowledge of effective prevention strategies, culturally sensitive programs, risk reduction/behavioral change, human sexuality, and drug and alcohol.
   - The responding agencies stated they served people primarily in City of Wilmington zip codes.
   - Prevention agencies noted the following top barriers to services: funding, public apathy, hours of operation, and stigma.
   - Five agencies noted the need for bi-lingual materials.

2. 2008 Consumer Survey
   278 PLWHA completed a Consumer Survey primarily regarding treatment and supportive services needs, availabilities, and barriers. Treatment findings are outlined on pages 89 through 94. For the first time, several prevention questions were added to the survey, with the following responses given:

   - Nearly one in ten respondents reported never being counseled about their risk of giving HIV to others.
   - One in five reported never or rarely telling their partner(s) about their HIV+ status.
   - One in five reported never or rarely talking to their partner(s) about safer practices.
   -

3. 2008 Provider Perspective Survey:
   HIV service providers completed the 2008 Provider Perspective Survey, a survey similar to the Consumer Survey, in which they were asked about their caseloads as a whole, focusing on the availability of services, not just their perceived importance. Treatment findings are outlined on pages 89 through 94. For the first time, several questions regarding prevention were asked in the Provider Perspective Survey about how they perceived their clients with regards to prevention behavior, with the following responses given:

   - Treatment providers perceived that approximately 44% of their clients had unprotected sex.
   - Treatment providers perceived that only 95% of their clients were counseled about the risk of spreading HIV.

4. Prevention/At Risk Survey:
   Through the summer of 2008, the Planning Council conducted its first-time Prevention/At-Risk Survey throughout the state at agency locations and public events. The survey was self-administered by 803 respondents. Some of the demographics and results are as follows:

   - 58% of respondents were male, 42% were female.
   - 54% were African American, 35% were Caucasian, 7% were Hispanic.
   - 57% lived New Castle County (with 46% in Wilmington 198.. zip codes), 13% lived in Kent, 14% lived in Sussex, 12% lived out of state.
   - 54% overall were tested in the last 12 months (30% males were tested, 24% females).
   - 55.6% were educated about HIV by themselves or others.
   - More African Americans were educated about HIV than other ethnic/racial groups; more females were educated than men.
   - 8.3% of youth from 13 to 19 said they had educated themselves; 15% said they had been educated by others.
   - 55.3% had unprotected sex (28.8% with multiple partners).
   - Only 20% always knew their partner's(s') status.

A sample of comments from the Prevention/At-Risk Survey follows:

- It's good to know where you can get help or information about HIV.
- Free HIV testing is a positive thing.
- More help for teenagers.
- Everyone needs to be tested.
- A lot of people don't realize that once you've had sex with one person that they have just slept with everyone they have slept with. I think bringing this to attention may help a little more.
- When I was pregnant, I found out that the father of my unborn child was HIV positive so I know I will have it soon. We've been together for three years and also shoot up after each other. The baby doesn't have it thank God and so far I don't yet.

D. Population/Intervention Prioritization Process

Following the needs assessment, the Plan process turned to methods used by the prior CPG Populations Work Group to prioritize the populations. Prioritizing populations helps determine where funding should be targeted and which services should be provided to impact groups most at-risk and to reduce the spread of the disease. The CPG Populations work group prioritized populations in accordance with the CDC initiative calling for a national emphasis on 'prevention for positives' (P4P) and requiring all jurisdictions to list HIV infected individuals as the top priority population. The CDC also defined five critical attributes related to setting priorities for target populations.

CDC-Defined Critical Attributes Related to Setting Priorities for Target Populations:

- Evidence that the size of at-risk populations was considered.
- Evidence that a measurement of the percentage of HIV morbidity (i.e. HIV incidence or prevalence), if available, was considered.
- Evidence that the prevalence of risky behaviors in the population was considered.
- Target populations are defined by transmission risk, gender, age, race/ethnicity, HIV status, and geographic location.
- Target populations are rank ordered by priority, in terms of their contribution to new HIV infections.

CPG Populations Work Group Assumptions:

- The presence of HIV must be the first consideration in identifying any population or geographic area.
- Given a relatively stable epidemic and the historical failure of other indicators and data sources to predict shifts and trends within Delaware's epidemic, additional data sources (STD rates, Behavior Risk Factor Surveillance system data, census data, and focus group data) are not reliably useful when identifying populations at-risk for HIV infection.
- These additional data sources, however, are useful in describing the conditions and behaviors within identified populations/geographic areas at risk for HIV infection.
- Funding realities demand that the CPG focus efforts and resources on specific populations, areas, and behaviors as identified by epidemiology.

Once populations have been prioritized, selecting appropriate interventions for them is the next step in the process. As a part of the Plan methodology, the prior Interventions Work Group used a CDC listing of seven attributes related to scientific effectiveness and cultural appropriateness was used to develop final recommended interventions. The attributes are as follows:

CDC Listing of Attributes for Help in Selecting Appropriate Interventions

- Demonstrated application of existing behavioral and social science, and pre- and post-test outcome evidence (including evaluation date, when available) to show effectiveness in averting or reducing high-risk behavior within the target population.
- Evidence that the prevention activity/intervention is acceptable to the target population.
- Evidence that the prevention activity/intervention is feasible to implement for the intended population in the intended setting.
- Evidence that the prevention activity/intervention was developed by or with input from the target population.
- Prevention activities/interventions are characterized by focus, level, factors expected to affect risk, setting, and frequency/duration.
- Each prevention activity/intervention is also characterized by scale and significance.
- Prevention activities/interventions are prioritized by risk population and their ability to have the greatest impact on decreasing new infections.

The CDC requires all health departments to evaluate interventions funded in their communities. To assist with standardizing this process, the CDC instituted definitions for each type of intervention (available at www.cdc.gov).

In the previous five-year plan, the Plan Interventions Work Group listed both *general* intervention categories *and* specific intervention models appropriate for each prioritized population. During the five-year period covered by the Plan, however, many of the specifically-listed interventions proved to be ineffective when implemented in Delaware (due partly to Delaware's small size and unique demographics) and/or became 'out-of-date'.

Rather than continuing this 'laundry list' of specific interventions, the Comprehensive Plan presents a list of recommended intervention types and leaves more latitude for DPH and service providers to explore and innovate with the suite of Diffusion of Effective Behavioral Interventions (DEBIs) and other evidence based interventions as they come available or are updated. Agencies seeking more effective intervention models are directed to the CDC's regularly reviewed and updated websites of approved interventions and are encouraged to work cooperatively with DPH to modify the interventions as needed for local implementation.

While agencies in Delaware are not limited to interventions on CDC websites (other evidence-based or theory-based interventions may be used), the CDC-approved interventions have already met recommended levels of effectiveness testing. Evidence-based interventions are identified by the CDC's HIV/AIDS Prevention Research Synthesis (PRS) Project, translated into user-friendly packages of materials by its Replicating Effective Programs (REP) project, and disseminated by its DEBI project. As of July 2009, the CDC's compendium included 37 best-evidence and 26 most-promising interventions. These are listed by type, while subset listings group the interventions by levels, risk category, race/ethnicity, and sex to allow for easier researching. The CDC's compendium can be found at the following websites:

- Best-Evidence Interventions:
  www.cdc.gov/hiv/topics/rsearch/prs/ best-evidence-intervention.htm

- Promising-Evidence Interventions
  www.cdc.gov/hiv/topics/rsearch/prs/promising-evidence-interventions.htm

Best-Evidence HIV behavioral interventions include interventions that have been rigorously evaluated and have shown significant effects in eliminating or reducing sex- or drug-related risk behaviors, reducing the rate of new HIV/STD infections, or increasing HIV-protective behaviors. These interventions meet the PRS efficacy criteria for best evidence and are considered to provide the strongest scientific evidence of efficacy. *Promising-Evidence HIV behavioral interventions* include interventions that have been sufficiently evaluated and have shown significant effects in eliminating or reducing sex- or drug-related risk behaviors, reducing the rate of new HIV/STD infections, or increasing HIV-protective behaviors. These interventions meet the PRS efficacy criteria for promising evidence and are considered to be scientifically sound and to provide sufficient scientific evidence of efficacy.

However, proven effectiveness under study conditions does not guarantee success when the programs are implemented in different local environments, with different funding levels, or within differing 'suites' of service. Providers are encouraged to adapt as needed to bring local implementation effectiveness in alignment with study expectations.

E. 2010-2014 Prioritized Populations and Recommended Interventions

The Comprehensive Plan recognizes the depth of work done by the prior CPG in developing the 2005 Plan recommendations, establishing a high level of credibility based upon the scientific process they utilized. The recommendations outlined in the prior plan remain a strong foundation upon which the recommendations in the Comprehensive Plan could be built.

To summarize the current process, over the last five years the Planning Council worked steadily towards the finalization of the prevention portion of the Comprehensive Plan. First, prevention and treatment planning groups merged, establishing of the Integrated Planning Council itself. Next, the Planning Council developed and conducted assessments and analyzed data from a variety of data and assessment sources to update and modify the 2005 Plan recommendations.

In keeping with the reordering of Delaware's most at-risk populations; the dispersion of Delaware's epidemic; the lowered utility of defining and targeting services by zip code as describe in the previous sections; and CDC emphasis on routinizing HIV screening and integrating/institutionalizing HIV prevention education whenever possible; the following are the prioritized population and intervention approaches for 2010-2014.

1. **HIV Infected Individuals**
    a. Partner Services
    b. Comprehensive Risk Counseling Services (CRCS)
    c. Health Education and Risk Reduction (HE/RR): Low-intensity, on-going risk-reduction counseling services for those not accessing CRCS
    d. Mapping and disruption of transmission networks through intensive cases-study data collection and analysis and resulting implementation of ad-hoc, custom intervention needed to address specific network conditions
    e. Location of those not known to be in care and reconnection to treatment/case management as needed (in cooperation with Ryan White and HIV surveillance)

2. **Heterosexuals of all races, with emphasis on African American in the Wilmington/NCC area and emphasis on women that are pregnant or considering pregnancy**.
    a. Social marketing/mass media recruitment to HIV screening services
    b. Outreach recruitment to HIV screening & distribution of risk-reduction supplies
    c. Rapid HIV Screening/Referral Services
    d. HE/RR

3. **Injected Drug Users**
    a. Outreach recruitment to HIV screening & distribution of risk-reduction supplies
    b. Rapid HIV Screening/Referral Services
    c. Needle Exchange (*not federally funded*)
    d. Multi-session Group Level Interventions/Individual Level Interventions (GLI/ILI) in residential treatment sessions

4. **Men that have Sex with Men (MSM), with special emphasis on African American and those frequenting the resort areas of Delaware.**
    a. Social marketing/mass media recruitment to HIV screening services
    b. Outreach recruitment to HIV screening & distribution of risk-reduction supplies
    c. Rapid HIV Screening/Referral Services
    d. HE/RR

5. **Youth in secondary school, college/university and correctional settings.**
    a. Institutionalization of HE/RR and HIV screening services in education and detention settings
    b. Social marketing/mass media recruitment to HIV screening services
    c. Rapid HIV Screening/Referral Services

F. Coordination and Linkages Between Prevention and Treatment Programs

Individuals, community agencies, planning groups and governmental partners benefit from coordinating programs for HIV prevention and treatment. The State of Delaware is fortunate in that its small size lends itself to effective communication and collaborations. Additionally, the Planning Council system contributes to this process by linking providers who work to bring services to those with HIV/AIDS along a continuum from prevention to treatment. Many of these collaborative efforts are documented in Chapter V: Treatment. Several examples are summarized as follows:

- Delaware's HIV prevention program has focused its activities in six primary areas as outlined on pages 68 to 69. All six areas provide coordination between prevention and treatment:
    - Outreach and education to recruit high-risk individuals to HIV testing services
    - Rapid testing as the standard of HIV counseling, testing and referral while maintaining alternates as possible
    - Connection to referral and partner services and treatment/case management for HIV+ individuals
    - Comprehensive risk counseling and services and interventions delivered to individuals for HIV+ individuals who continue to engage in behaviors known to transmit HIV to others or place the HIV+ individual's health in jeopardy
    - Needle exchange program
    - Social marketing of services within high-risk populations

- The Planning Council brings together professionals and PLWHA to participate in the HIV/AIDS planning process, determining how funding can best be used to prevent the spread of the disease and treat those who have it: pages 7 through 13.

- PLWHA can participate on the Consortium's Planning Council, Policy Committee, Red Ribbon Advocates, and Patient Advisory Groups, pages 12 to 13. Such groups provide opportunities and education to clients, empowering them to make decisions about their health, advocate for change, and share concerns with other consumers. These empowered clients are able to reduce their risky behavior and educate their peers with messages that use their language, spirit and ideas.

- Because of its size, Delaware is unique in that the majority of PLWHA (61%) are treated at one of eight treatment centers throughout the state: the A.I. DuPont Hospital for Children, Veterans Affairs Medical Center, or one of six Christian Care Health Services (CCHS) clinics throughout the state, allowing for close relationships between medical providers, community outreach programs, case managers, and other providers of care and prevention. (See pages 72 to 73.) Examples of several CCHS collaborations are as follows:
    - CCHS, DPH, and the Center for Substance Abuse Treatment coordinate with Brandywine Counseling (page 69) to provide an infectious disease clinic at Brandywine's methadone clinic.

  - CCHS has a satellite office within Beautiful Gate Outreach Center that allows for referral to treatment on site (pages 65 to 66).
  - DPH Ryan White staff and CCHS collaborate to provide mental health care for patients who access clinic care, through funding for a Licensed Clinical Social Worker. Unfortunately, this funding is only available in New Castle County.

- DPH Ryan White and DPH Prevention STD collaborate to provide interventions connecting PLWHA to HIV Referral and Partner Notification services through the work of the STD programs Disease Intervention Specialists. (See page 68.)

- The Consortium's Policy Committee and DPH worked closely with Brandywine Counseling to have a Needle Exchange Program approved by the state legislature within targeted areas of the City of Wilmington. The program, through its on-site distribution of needles, has successfully linked prevention and treatment for a number of HIV+ IDUs. Additionally, it has successfully encouraged testing among hundreds of non-IDUs in the community.

- Case Management Services have evolved in Delaware, moving from a hospice care model to an empowerment model. The transition was a collaborative initiative among the Delaware HIV Consortium, DPH Ryan staff, Medicaid AIDS Waiver Programs, DSAMH, and HRSA.

- In the clinic settings, heightened risk screening is performed, followed up with closely coordinated CBO-based providers providing PCRS services.

- Linkages with the City of Wilmington, federal housing programs, and the Delaware Housing Authority have enabled the Delaware HIV Consortium to provide housing assistance to over 140 PLWHA each year. Stable housing is a vital part in both prevention and treatment for HIV+ persons.

- The most recent 2009-2011 Resource Guide was completed through the cooperation of the over 200 agencies in the guide and Planning Council members who updated the information. Additional Spanish interpretation was added throughout the book, which is full of prevention and treatment information and services. The guides are provided to service providers to inform clients of available services and are provided to clients, as well, so they have the information at their fingertips.

Prevention Closing

As the epidemic changes, this document will continue to be updated annually to best meet the needs of PLWHA in Delaware and to prevent the spread of HIV. The new programs being implemented, in particular, will bear additional monitoring for effectiveness and viability.

Chapter V provides information on how Delaware is responding to the HIV epidemic in terms of treatment measures. Section I describes the history of the response to the epidemic. Section II provides a description of the current continuum of care. Section III assesses needs, barriers to care, gaps in services, and across system barriers.

Section I: History of the Local, State, and/or Regional Response to the Epidemic

A. Introduction

The State of Delaware receives federal funding for HIV care through the Division of Public Health (DPH) HIV/STD/Hepatitis C Program. DPH is the primary recipient of Ryan White funding from HRSA, specifically Part B of the Act. The aim of this federal funding is to improve the quality and availability of medical care to uninsured and underinsured individuals and families affected by HIV disease. Christiana Care Health System (CCHS) is the second recipient of Ryan White funds in the state of Delaware, receiving Part C and Part D funds. CCHS is also part of the North Eastern region—headquartered in Pittsburgh—that receives AETC funding (Part F).

B. Description of the Ryan White Program

The Ryan White HIV/AIDS Treatment Modernization Act of 2006, (former the CARE Act) is federal legislation that addresses the unmet health needs of persons living with HIV disease (PLWHA) by funding primary health care and support services that enhance access to and retention in care. First enacted 1990, Congress amended and reauthorized it in 1996, 2000, and 2006. The Act reaches over 500,000 individuals each year, making it the federal government's largest program specifically for people living with HIV disease. Funding is provided through five different "Parts".

Part A provides emergency relief assistance to "eligible metropolitan areas" (EMAs) and Transitional Grant Areas (TGAs) that are most severely affected by the HIV/AIDS epidemic. To be an eligible EMA, an area must have reported more than 2,000 AIDS cases in the most recent five years and have a population of at least 50,000. To be eligible as a TGA, an area must have reported at least 1,000 but fewer than 2,000 new AIDS cases in the most recent five years. (As of 2005, Delaware does not receive Part A funds.)

Part B provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five U.S. Pacific Territories or Associated Jurisdictions. Part B grants include a base grant, the AIDS Drug Assistance Program (ADAP) award, ADAP supplemental grants and grants to States for Emerging Communities. (See below.) Funding is distributed via formula and other criteria. Seventy-five percent (75%) of Part B funds must be used to fund "core medical services": outpatient and ambulatory health services, ADAP, AIDS pharmaceutical assistance, oral health care, early intervention services, health insurance premium/cost-sharing assistance, home health care, medical nutrition therapy, hospice care, community-based health services, substance abuse outpatient care, and medical case management, including treatment adherence services. The remaining 25% of funds must go to support services that are needed for people living with HIV/AIDS to achieve their medical outcomes, such as respite care, outreach services, medical transportation, linguistic services, and referrals for health care and support services. In 2008, the State of Delaware was awarded $5,226,249 in Part B funds ($1,934,704 in base funding, $3,291,545 in ADAP, and $237,170 in Emerging Communities funding (below).

Emerging Communities

The CARE Act amendments of 2000 established a program for providing supplemental grants to States (Part B recipients) with Emerging Communities (cities with 500-1,999 reported AIDS cases in the most recent 5-year period). The legislation segments these communities into two tiers. Tier 1 consists of cities with 1,000-1,999 reported AIDS cases; Tier 2 consists of cities with

500-999 cases (in FY 2004 that included the New Castle County DE/Cecil County MD metropolitan areas). Funding for the Emerging Communities program is divided equally between the two tiers. (See Delaware allocation above.)

Part C provides grants directly to service providers such as ambulatory medical clinics to support outpatient HIV early intervention services and ambulatory care. Part C also funds planning grants, which support organizations in more effectively delivering HIV/AIDS care and services and capacity development grants to enhance a grantees capacity to develop, strengthen, or expand access to high quality HIV primary health care services for people living with HIV or who are at risk of infection in underserved or rural communities and communities of color. In 2007-2008, CCHS received $725,725 in Part C funding.

Part D provides funding for family-centered care involving outpatient or ambulatory care (directly or through contracts) for women, infants, children, and youth with HIV/AIDS. Grantees are expected to provide primary medical care, treatment, and support services to improve access to health care. Part D funds family-centered primary and specialty medical care, support services, and logistical support and coordination. In addition, grantees are to educate clients about research and research opportunities and inform all clients about the benefits of participation and how to enroll in research. In 2007-2008, CCHS received $306,765 in Part D funding.

Part F disburses three types of grants.

- The Special Projects of National Significance (SPNS) Program advances knowledge and skills in the delivery of health and support services to underserved populations diagnosed with HIV infection. SPNS grants fund innovative models of care and support the development of effective delivery systems for HIV care.
- The AIDS Education and Training Centers (AETC) Program of the Ryan White HIV/AIDS Program supports a network of 11 regional centers (and more than 130 local associated sites) that conduct targeted, multidisciplinary education and training programs for health care providers treating people living with HIV/AIDS. The AETCs serve all 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, and the 6 U.S. Pacific Jurisdictions. In 2007-2008, CCHS AETC received $292,444 in Part F funding.
- Funds from all grant programs of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 can support the provision of oral health services. Two programs specifically focus on funding oral health care for people with HIV: the Dental Reimbursement Program (DRP) and the Community-Based Dental Partnership Program (CBDPP). The DRP assists accredited dental schools and post-doctoral dental education programs with uncompensated costs incurred in providing oral health treatment to patients with HIV disease. The CBDPP was first funded in FY 2002 to increase access to oral health care services for HIV-positive individuals while providing education and clinical training for dental care providers, especially those in community-based settings.

C. General Distribution of Part B Funding

1. CCHS: DPH allocates a large portion of its Part B funding to CCHS to provide prescription drugs, psychological counseling, medical assessment, and primary medical care to HIV-infected individuals. The funds are also used to run a HIV medication adherence clinic. Between October 1, 2007 through March 31, 2009, DPH contracted $2,191,193 to CCHS for medical and counseling services and $1,800,000 for medications. CCHS uses other funding streams to provide clinician training, health education/risk reduction, laboratory testing, eye exams, and medical social work.

2. Delaware HIV Consortium: The Delaware HIV Consortium receives an allocation of Part B funding ($1,377,463 in FY 2008) for supportive services, including case management, emergency financial assistance, food and nutritional services, transportation, outreach, and related services. These dollars also support the community planning processes for HIV Prevention and Treatment, as well as the provision of technical assistance and on-going training for HIV Service Providers. As the sole Ryan White Part B Consortia in Delaware, the Delaware HIV Consortium is charged with bringing together community-based organizations, medical care providers, case managers, and people living with HIV/AIDS to participate in planning services for HIV prevention and treatment issues. (The Delaware HIV Consortium's involvement in community planning processes is outlined on pages 7 through 13.)

3. AIDS Drug Assistance Program (ADAP): The DPH HIV/STD Program coordinates Delaware's ADAP Program. ADAP provides medications from an approved formulary developed by the Formulary Committee. This committee recommends changes to the formulary and submits those suggestions to the DPH's Ryan White Care Act (RWCA) program, which approves any changes and provides feedback to the committee. The committee reviews the most current HIV Treatment guidelines, expenditures, utilization, requests from providers, and other appropriate factors in updating the Delaware ADAP Formulary. Currently, there is no waiting list among ADAP clients in Delaware for AIDS medications. Eligible clients fill their prescriptions at either a CCHS HIV Wellness clinic (if they do not have insurance coverage) or a retail pharmacy (if they have health insurance but need ADAP co-payment assistance). Each client that uses a retail pharmacy is given an ADAP card that can be taken to any pharmacy in the state that will accept the terms and conditions of the ADAP. That pharmacy will fill any prescription for any medication on the current approved ADAP Formulary. Table 11 describes the ADAP funding cycles for the last four fiscal years. As demonstrated, the grant allocations for ADAP and total expenditures have diminished over the last several years. For Fiscal Year 2008, the ADAP allocation was $3,291,545.

Table 9: Delaware AIDS Drug Assistance Program (ADAP) Funding

Fiscal Year	2004	2005	2006	2007	2008
Grant Allocation for ADAP	$3,312,158	$3,202,722	$3,486,482	$3,312,158	$3,291,545
Total Expenditure on Medications	$2,042,844	$1,875,048	$2,049,589	$2,821,572	unknown
Unduplicated clients served*	485	464	461	637	unknown
Average ADAP Cost/Client/Year	$4,186	$4,041	$4,446	$4,429	unknown

**HIV case managers are proactive in enrolling new and continuing ADAP applicants on the federal Medicaid Program, ensuring that Ryan White is payer of last resort.*

ADAP is responsible for only a portion of the prescription cost (co-pay) for certain clients. An assistance level for each client is dependent on a client's financial status, which is calculated based on the federal poverty level (FPL) and on the availability of health or prescription coverage for the client.

The 2008 National ADAP Monitoring Report by Kaiser Foundation reported $100,147,921 in ADAP expenditures and 101,987 clients served in June 2007. In Delaware, Public Health Pricing for medications dispensed at CCHS, manufacturers' drug rebates for certain prescriptions, and the use of other state and federal funds (such as the Veterans Administration funds) have assisted with lowering the average annual client cost for ADAP.

D. Consumer Involvement in HIV Planning and Healthcare

It is very important that consumers have opportunities to participate in both the planning and treatments processes. As outlined on pages 12 to 13, consumers have these opportunities through several programs. As members of the Delaware HIV Consortium and its Planning Council, PLWHA

can choose to participate in work groups that help develop long-range prevention and treatment plans. By participating on the Consortium's Policy Committee, PLWHA can help assure that effective policies are in place for the HIV/AIDS community. As Red Ribbon Advocates, consumers learn advocacy skills in public speaking, letter writing, and phone calling. Regarding involvement in HIV healthcare, CCHS's *Patient Advisory Groups* operate in each of the state's three counties and the *Peer Education Wellness Foundation* (currently suspended as a separate entity) still is operating within the CCHS system. (Again, see pages 12 to 13 for a description of each of these programs.)

E. HIV Medical Care and Support Services Funded Through the Ryan White Program

As stated, Delaware provides HIV medical care for uninsured, underinsured and low-income people with HIV disease. Support services, provided either as state direct services or through the Delaware HIV Consortium, are available. ADAP continues to provide FDA-approved HIV medications. All allocations and priorities for funding are based on funding availability for the Part B Program. CCHS is the main provider of HIV medical care in the state, operating its program with several sources of Ryan White funding, as well as other funding.

1. HIV Medical Care

CCHS receives direct HIV federal funding in the form of Ryan White Parts C and D. It also receives Part F (AETC) funds by collaborating with the North Eastern region based in Pittsburgh. The grants are all coordinated through the HIV Community Program office in Wilmington, DE. Also, as stated earlier, CCHS also operates on an award of $2,191,193 from the FY 2008 Part B (state) funding. The allocation provides funding for ambulatory/outpatient medical care, HIV medication adherence program, mental health counseling and treatment, medical social work, laboratory costs, eye exams, physician training, primary care nursing, health education/risk reduction, patient education and drug reimbursement.

Table 10: Direct HIV Federal Funding to Christiana Care Health System

Fiscal Year	2004-2005	2005-2006	2006-2007	2007-2008
Part F (AETC)	$308,517	$301,840	$293,444	$292,444
Part C	$761,769	$744,381	$725,725	$725,725
Part D	$306,765	$306,765	$306,765	$306,765

CCHS runs six HIV Wellness clinics, which are staffed with board certified Infectious Disease (ID) specialists. Four clinics are located in New Castle County, each within the City of Wilmington, and one each is located in Kent County and Sussex County. According to the 2007 CARE Act Data Report, 1,374 HIV-infected clients made 8,960 visits to the six clinics in that year. Information on the six clinics follows.

- Wilmington Hospital Annex: In Wilmington, the Wilmington Hospital Annex serves as the main infectious disease clinic and houses the administrative offices for the entire program.

- Porter HIV Wellness Clinic: A satellite clinic at the Porter State Service Center is funded through Ryan White Part C as an Early Intervention Services (EIS) site. State funds cover costs associated with the clinic space and some supplies. Disease Intervention Specialist (DIS) staff in the DPH/STD program directly refer HIV positive clients to the Porter HIV Wellness Clinic staff. Through agreement with DPH, patients at Porter HIV Wellness Clinic receive partner notification services and STD screening. EIS staff provides clinical care and services to HIV-infected patients two days per week.

- Beautiful Gate Outreach Center (BGOC): In addition, the EIS staff provides clinical care at BGOC. BGOC is affiliated with Bethel AME and provides HIV counseling and testing,

community education and outreach, and supportive services. The EIS staff is on site one day per week providing medical care to patients who prefer this setting to other clinical locations.

- Brandywine Counseling/Lancaster Community Program: The fourth site in Wilmington for HIV medical care is at Brandywine Counseling/Lancaster Community Program. This specialty clinic provides care for HIV-infected substance abusers. The staff jointly manages patient care with substance abuse support groups, methadone treatment programs, and case management.

- Kent County Wellness Clinic: In Kent County, the Kent County Wellness Clinic operates from a DPH-controlled long-term care facility. The clinic serves Kent County patients and southern New Castle County patients for whom the commute to Smyrna, Delaware is more convenient than to Wilmington.

- Georgetown: In Sussex County, the Georgetown Clinic is operated at the Stockley Campus in collaboration with DPH. Patients seen at this facility have the option of case management provided on-site through DPH, the clinic or off-site with Community Based Organization (CBO) staff.

2. Other Health-Care Related Services Funded by Part B

   For Georgetown clinic patients (Sussex County) Beebe Medical Center receives Part B funds to provide outpatient X-rays and Quest Laboratories to conduct laboratory testing. Additionally, DPH works closely with the Department of Correction to ensure adequate medical care for HIV-infected inmates. Upon release, HIV-infected inmates are provided a 30-day supply of all HIV-related medications, in what is known as the bridge medication program. Department of Corrections provides transitional case management for inmates leaving the correctional system in Delaware. HIV-infected inmates are provided transitional case management 30 days prior to release, and then the inmate is transitioned to a community case manager.

3. Delaware HIV Consortium Sub-Contracted and Direct Services

   - Sub-Contracted Services: DPH provided $1,377,463 in FY 2008 to the Delaware HIV Consortium to conduct treatment services planning and provide support services to HIV-infected clients. Community-based organizations submit proposals based on a Request for Proposal (RFP) for supportive services at the state, county, or city level. Contracts are developed to provide case management, emergency financial assistance, food service programs, and transportation. Mental wellness counseling and nutritional counseling are provided on a fee-for-service basis.

     In 2008, agencies that were funded through these contracts were: AIDS Delaware, Brandywine Counseling Inc., Case Management Services Inc., Catholic Charities, Connections Community Support Program, Kent/Sussex Counseling Services, Ministry of Caring/House of Joseph II and Sussex County AIDS Council, Inc. Cecil County (Maryland), allocated funds from the Emerging Communities portion of the Ryan White Part B grant, has two contracts for HIV supportive services—one for HIV/AIDS case management and the other for transportation services.

   - Health Insurance Program: The Consortium also receives $140,000 of ADAP funds to run a Health Insurance Program. The Health Insurance Program serves clients who have private health insurance either through an employer, a COBRA plan, or an individual plan. During FY 2004, the program served 14 clients. The Consortium also receives Delaware State funds

to supplement the program and serve clients whose prescription coverage is not equal to or better than the ADAP Formulary.

- Coordination of Service Delivery: Consortium staff coordinates service delivery with the DPH RWCA administration. A RWCA Services Manual outlines eligibility for each service offered, required forms, and other pertinent information for service delivery. There are plans to have the manual on the Consortium website shortly. Quarterly meetings with Consortium and DPH administration serve as the basis for communicating significant problems and issues with the program. Case management agencies learn of developments in the RWCA program through case manager supervisor meetings with DPH and Consortium administration. Routinely, the RWCA administrative specialist emails broadcast messages to all case managers in the state.

4. Home and Community-Based Services
   DPH allocates funds to cover homemaker services and durable medical equipment under the category of "health and community based services". A total of $5,000 was allocated for these services in FY 2008. The services were directly billed to DPH.

5. State Direct Services
   Delaware allocated $839,398 in FY 2008 for state direct services, which included nutritional supplements, disposable medical supplies, laboratory fees, and X-rays. Insurance co-pays, eye exams/glasses, dental care, mental healthcare, transitional case management, and other clinical services, including provider training and client education, are also in this state direct services category.

F. Coordination of Services Between HIV Prevention and Part B-Funded Services

As stated in Chapter IV, Delaware's size contributes to easier collaboration than may be found in larger jurisdictions. Examples of such coordination are included in this section.

- DPH RWCA administration works closely with DPH HIV and STD Prevention staff. Each of these programs is functionally within the Communicable Disease Branch in the Health Promotion and Disease Prevention section of DPH. Weekly meetings with program administration allow for cross-program activities and communication to occur effectively. Two operating committees of the Delaware HIV Consortium—the Delaware HIV Planning Council and the Policy Committee—have representation from both DPH RWCA and HIV Prevention.

- All HIV Prevention contracts for health education and risk reduction include STD and HIV education components. All HIV counseling and testing-contracted agencies (funded both through HIV Prevention and Family Planning grants) work with the local CCHS ID clinic sites for referral to treatment. EIS staff operate through contracts between the Delaware HIV Prevention Program and community-based organizations. Goals of these contracts include locating individuals testing positive at HIV counseling and testing sites and recruiting and referring them to appropriate medical care.

- The perinatal HIV prevention program reviews labor and delivery, maternal, and infant charts for documentation of compliance with Delaware Code Title 16, chapter 12. The state legislation has just been changed to include HIV/AIDS testing as a part of the standard battery of tests offered to pregnant women, thus reducing some of the stigma associated with taking the test. Documentation of Opt-Out refusal of the test is required. The HIV Prevention program partnered with the PA/MidAtlantic AETC to educate obstetricians and nurse practitioners about Public Health Services (PHS) guidelines and the Delaware Code.

Delaware's HIV prevention program has focused its activities in six primary areas:

1. Outreach and Education to Recruit High-Risk Individuals to HIV Testing Services: Outreach programs have been in operation for many years but in 2004-2005 were redirected from the primary objective of education to a primary objective of recruitment of high-risk individuals to HIV counseling, testing and referral (CTR) and other more in-depth services. Technical assistance (TA) to improve outreach services was requested from Centers for Disease Control (CDC) and delivered in 2006. TA is ongoing and in 2008 Social Networking interventions were added to community-based organization programs to further increase ability to locate and test those in high-risk networks.

2. Providing Rapid Testing as the Standard of HIV Counseling, Testing and Referral (CTR) While Maintaining Alternates as Possible: The HIV Prevention Program coordinated with the State Laboratory, Family Planning and the Division of Substance Abuse and Mental Health (DSAMH) to implement rapid testing as the standard of HIV testing services in all public health clinics, family planning contract providers, and drug treatment centers throughout Delaware. Rapid HIV testing now accounts for over 97% of all DPH-sponsored testing in the state. Anonymous testing will be available by request at one DPH site in each county and agencies that primarily serve Latino populations (to ensure availability of Spanish speaking counselors).

3. Providing Connection to Referral and Partner Services (RPS) and to Treatment/Case Management Services for HIV Positive Individuals: HIV CTR providers actively refer HIV+ clients to HIV RPS/partner notification (PN) services provided by DPH through the STD program's Disease Intervention Specialists (DIS). Linkages between HIV prevention providers and DPH DIS/PN staff have been improved by reconfiguring the cast reporting system to include the HIV Prevention Program Evaluator in the reporting chain and provide better follow-up on case outcome.

4. Providing Comprehensive Risk Counseling & Services (CRCS) (Formerly Prevention Case Management) and Individual Level Interventions (ILI) for HIV Positive Individuals Who Continue to Engage in Behaviors Known to Transmit HIV to Others or Place the HIV Positive Individual's Health in Jeopardy: In 2007, an unsuccessful attempt to integrate PCRS services into treatment and Ryan White case management programs begun in 1995 was terminated. The service has been reorganized to have heightened risk screening performed in the clinic setting and to have a closely coordinated CBO-based provider provide PCRS services. This system has improved both recruitment and retention of clients accessing PCRS services.

5. Needle Exchange Program: With funding from the State of Delaware, Brandywine Counseling has operated a needle exchange in the City of Wilmington since February 1, 2007 out of its Lancaster Program office. The exchange program operates five days per week at eight unique sites, with staff spending four hours each day at two of the sites. To date, the program has exceeded expectations. One of its primary goals was to link at least five substance abusers per year to treatment; currently, 19 have been enrolled. Other accomplishments as of July 2009 include the following:

    - 583 substance abusers have registered for the needle exchange program
    - 377 exchangers are men; 206 are women, a much higher figure than other programs across the nation; almost 60% are between the ages of 25-34
    - During cooler months, 60-80 exchangers exchange 600-800 syringes per month
    - During warmer months, 80-100 exchangers exchange 1,000-1,200 syringes per month

- On average, 700 syringes are exchanged each month
- Since acquiring a van in November 2007, 639 non-clients have been tested for HIV
- 255 exchangers (about 50% of the total) have been tested for HIV as well
- Of the 255 tested, 12 tested positive and are in treatment at the Lancaster Community Program

Successes in the program are due to several factors. Brandywine Counseling is a comprehensive organization with its own case management staff and a CCHS clinic, with on-site treatment for clients. This set-up creates efficiency and streamlines linkages to care, removing typical obstacles to treatment for this type of clientele. Because of the small size of both the City of Wilmington and Delaware, communications among agencies is easy. The original program timeframe called for waiting five years to begin discussion for location expansion beyond Wilmington's city limits. Because the program has been so successful, however, DPH has given permission to expand the program to Route 9 and Route 13, both high drug traffic areas outside of the City. The program's Oversight Committee is working on presenting the expansion plan to the state legislature for approval.

6. Social Marketing of Services Within High-Risk Populations

In 2007/2008, DPH ran two pre-produced ads to promote HIV testing among African Americans, produced and aired two original ads encouraging HIV testing among pregnant women (with emphasis on African Americans), and produced an original ad promoting HIV testing and sero-disclosure among MSM (to air in 2009). The goals of HIV prevention marketing are to:

- Increase HIV testing among those at highest risk for HIV infection;
- Increase the number of HIV positive individuals (with previously unknown HIV status) discovered through the increased testing;
- Reduce the number of individuals who enter into HIV/AIDS treatment services already symptomatic and/or AIDS-defined;
- Increase the overall awareness of the various HIV prevention service providers as a coordinated continuum of care.

G. Coordination of Services Between Substance Abuse Prevention and Substance Abuse Treatment and Part B-Funded Services

The DPH RWCA program collaborates with the Division of Substance Abuse and Mental Health (DSAMH) to provide quality medical and mental health services to HIV-infected substance abusers and mentally ill patients.

1. Substance Abuse Treatment

Through joint funding with Center for Substance Abuse Treatment (CSAT), DSAMH, DPH and CCHS, Brandywine Counseling is able to operate an infectious disease clinic at their methadone clinic in the Lancaster Community Program office in Wilmington (New Castle County). The Lancaster project combines support groups for substance abusers who are HIV-infected, medical care, adherence clinics, and referrals to on-site psychiatric care. The program has been in operation for ten years. It is a model program, providing "one-stop shopping" for a clientele who otherwise do not always follow-through with treatment if it involves making and keeping appointments in multiple locations.

2. Mental Health Care

DPH RWCA staff and CCHS work together to provide mental health care for patients who access care with the HIV program. A Ryan White Part C program-funded Licensed Clinical Social Worker (LCSW) provides assessment and on-going counseling at the Wilmington Hospital Annex. In FY 2007, the LCSW provided care to 166 unduplicated clients for 694 visits. Initial mental health screenings, on-site evaluation and referral, if needed, are available to all clients. Brandywine Counseling incorporates mental health assessment and treatment into the drug treatment program provided to those patients.

Unfortunately, federal funding through the federal Substance Abuse and Mental Health Services Administration did not continue in support of a critical program in Kent and Sussex County—the *Meeting the Challenges* (MTC) program. MTC provided on-site mental health/substance abuse treatment to patients accessing care at the Smyrna and Georgetown clinics. In the five years of funding, MTC provided this essential service to 168 patients with co-occurring illness. The loss of these funds has resulted in a significant gap in services, particularly in Kent and Sussex Counties where there is no public transportation and geographic dispersion of services presents a significant barrier to care.

3. Case Management Systems

The HIV/AIDS Case Management Program in Delaware continues to evolve in response to federal mandates and client needs. In 2003, the HIV/AIDS case management system and the continuous treatment team models underwent a profound paradigm shift: moving away from a hospice care model to an empowerment model. This transition was spearheaded as a collaborative initiative between the Delaware HIV Consortium, the Ryan White Part B Program at DPH, and the Medicaid AIDS Waiver Program, with technical assistance from the Health Resources and Services Administration (HRSA). DPH RWCA staff worked closely with the Delaware HIV Consortium, DSAMH and Medicaid [operated through the Division of Medicaid & Medical Assistance (DMMA)] to streamline the process.

In 2008, in response to language in the Ryan White Modernization Act of 2006, the HIV/AIDS Case Management Program began a second paradigm shift, changing its service to Medical Case Management, a process that will take approximately two years. It will include a major revision to the HIV/AIDS case management standards, the introduction of an online data collection and reporting system, the development of formal training modules for all HIV/AIDS case managers working in the state, and stronger linkages between the provision of HIV/AIDS case management and the monitoring of HIV health outcomes.

HIV/AIDS case managers received continuing education on HIV/AIDS and its relationship with substance abuse and mental health to allow better communication between the Ryan White Treatment program and Mental Health and Substance Abuse Prevention and Treatment programs.

H. Coordination With Other Ryan White Program Parts in Delaware

As described earlier, Delaware receives funding under the Ryan White Program Parts B, C, and D and also receives funding through the PA/MidAtlantic AIDS Education Training Center (AETC). Delaware DPH is the grantee for Part B funds. CCHS is the grantee for Parts C and D and receives AETC funds from the Pennsylvania/MidAtlantic AETC as a local performance site. CCHS receives Part B funding through a contract with DPH and provides funding for the Smyrna and Georgetown satellites. Ryan White Parts C and D fund clinics at the Lancaster Community Program, Beautiful Gate Outreach Center, and Porter Center. The AETC will continue to jointly sponsor lectures in each of the three counties describing and incorporating HIV testing in routine prenatal care, as

recommended by the Institute of Medicine. CCHS does not receive any funding from DPH for prevention or for educational activities at this time.

DPH HIV/AIDS/STD/Hep C Director and staff and CCHS Director and management team meet on a regular basis to discuss program goals and to identify and resolve challenges to client care. Also, members of the CCHS staff represent Parts C and D on the Consortium's Planning Council.

I. Collaboration With Other Federally-Funded Programs

Delaware DPH RWCA program staff interact with staff of other federally-funded programs in the provision of services for persons with HIV/AIDS. The Veterans Affairs Medical Center, HOPWA, Community Development Block Grant and Medicaid programs collaborate with RWCA programs on a regular basis. Brief descriptions of program activities are presented below.

1. Veterans Affairs

   The nurse/case manager at the Veterans Affairs Medical Center (VAMC) is on the mailing list for the Delaware HIV Planning Council as well as a member of its Technical Advisory Committee. The VAMC is also represented on HIV/AIDS planning activities, such as the development and revision of the SCSN.

2. Housing Programs

   - Housing Opportunities for Persons with AIDS (HOPWA)

     In 2009, approximately $760,000 of housing assistance was provided to Delawareans living with HIV/AIDS, through HUD's Housing Opportunities for Persons with AIDS (HOPWA) dollars. Two local governmental organizations administer these federal housing dollars. The first is the City of Wilmington, which allocated $585,986 to HOPWA-eligible housing activities. Those dollars were in turn awarded to four community-based organizations: the Delaware HIV Consortium ($480,986), the Ministry of Caring ($48,000), Catholic Charities ($34,000), and Cecil County, MD ($23,000). The City of Wilmington expects its FY 2009 award to assist a total of 125 client households. The second governmental organization that administers HOPWA dollars in Delaware is the Delaware State Housing Authority (DSHA). In FY 2009, DSHA awarded a $179,000 HOPWA grant to provide housing assistance for persons living with HIV/AIDS in Kent and Sussex Counties only. DSHA contracted with only one organization to provide this assistance—the Delaware HIV Consortium.

   - Delaware HIV Consortium Housing Program

     The Delaware HIV Consortium uses its HOPWA grants to operate the Delaware Housing Assistance Program (DHAP), which provides tenant-based rental assistance to low-income Delawareans living with HIV/AIDS in need of affordable housing. As of FY 2008, DHAP assisted 141 households throughout the state. By the end of the grant year, 89% of assisted households had maintained stable housing. The average monthly rental assistance was $533, $503, $445 and $431 per household in the City of Wilmington, New Castle County outside the City of Wilmington, Kent County and Sussex County respectively. As of December 1, 2008, DHAP's statewide waiting list contained 331 eligible individuals. Time spent on the waiting list is up to four years. While DHAP receives most of its funding from HOPWA contracts, it also receives funding from Delaware's Ryan White Part B award. In 2008, $202,000 of Ryan White dollars was allocated to DHAP housing assistance.

   - WomanSpace

     The Delaware HIV Consortium also receives a HOPWA grant to administer WomanSpace, a permanent supportive housing facility for formerly homeless women living with HIV/AIDS

and behavioral health disorders. Originally funded in 1999, WomanSpace was renewed for HOPWA funding in 2004 and again in 2007 to continue program operations through 2010. Located in downtown Wilmington within walking distance of HIV medical care and behavioral health services, WomanSpace opened in May 2002 and has operated at full capacity ever since. The facility contains ten furnished apartments with round-the-clock staffing, onsite supportive services, and access to other needed health care and services through referrals provided by a network of HIV/AIDS case managers funded by the Ryan White CARE Act and the Medicaid AIDS Waiver Program.

- Delaware Center for Justice
  The Delaware Center for Justice receives a grant from the City of Wilmington for transitional housing for inmates just released from the Delaware Correctional system. Funding covers short-term housing and utilities, up to 60 days. For FY 2008, DCJ's transitional housing program is currently funded in the amount of $26,000 through Community Development Block Grant (CDBG) dollars; however, funding has been reduced each year.

3. Medicaid
   The Division of Medicaid & Medical Assistance (DMMA) program provides medical insurance coverage to all Delawareans earning less than 180% of the federal poverty level. The Medicaid Waiver Program provides medical insurance coverage to those who are AIDS defined and earn less than 250% of the federal poverty level. This waiver program provides fee-for-service medical care payment to any provider for covered services. Services include case management, personal care, nutritional supplements, respite care and mental health. Under contract with DMMA, DPH case managers provide HIV case management for non-Waiver clients. These case management services are provided in-kind to the Ryan White Part B Program.

J. Assessment of Need – Includes Individuals In and Out of Care

1. HIV Medical Care Needs (Core and Other Support Services)
   Following the Centers for Disease Control and Prevention's (CDC's) initiative "Advancing HIV Prevention: New Strategies for a Changing Epidemic" that aims at identifying significant new numbers of PLWHA who will be seeking services, states were advised in FY 2005 to ensure that access to primary medical care and medications was not hampered. To this end, states were expected to prioritize and allocate funds to essential Core Services, which were defined by HRSA as: a) Primary Medical Care consistent with Public Health Service (PHS) Treatment Guidelines; b) HIV-Related Medications; c) Mental Health Treatment; d) Substance Abuse Treatment; e) Oral Health; and f) Case Management.

   a. Primary Medical Care
      Currently, the greatest challenge in the provision of primary medical care is provider capacity. The private sector does not have the multidisciplinary staff to handle complicated patients with co-morbid conditions such as substance abuse and/or mental health or social issues such as underinsurance or lack of transportation. A survey conducted in the fall of 2005 revealed that although private providers in New Castle County were accepting referrals for patients requiring HIV management, all required documentation of insurance coverage; and some practices required pre-approval by the primary care physician. In Kent and Sussex Counties, there were no providers accepting new patients for HIV management, regardless of insurance status. Currently, there are eight HIV/AIDS Treatment Centers statewide that care for those infected with HIV in the State of Delaware. These centers are as follows:

- Alfred I. DuPont Hospital for Children New Castle County (NCC)
- Veterans Affairs (VA) Medical Center (NCC)
- CCHS - Wilmington Hospital Annex (NCC)
- CCHS - Lancaster Community Program Office at Brandywine Counseling (NCC)
- CCHS - Porter HIV Wellness Clinic (NCC)
- CCHS - Beautiful Gate Outreach Center (NCC)
- CCHS - Kent HIV Wellness Clinic (Kent County)
- CCHS - Georgetown HIV Wellness Clinic (Sussex County)

The Treatment Centers system provides medical services to approximately 60% of all HIV positive clients seeking medical treatment; 35% of HIV positive clients are treated by private physicians with varying backgrounds (primary medical care physicians, infectious disease physicians, internists, and nurse practitioners) and, therefore, are not linked into an integrated model of care. The remaining 5% receive treatment through the Department of Correction.

Table 11: Number of HIV Patients Seen by Individual Providers in Delaware in 2008 (as of 12/22/08—Not Inclusive of Entire Year for CCHS)

Treatment Centers/Clinics or Physicians	Practice Type	2008 HIV/AIDS Clients (Unduplicated)	Area of Service
Treatment Centers/Clinics			
A. I. DuPont Hospital for Children	HIV Specialty	44	Statewide
Veterans Affairs Medical Center	HIV Specialty	140	Statewide
CCHS - Wilmington Hospital Annex	HIV Specialty	657	New Castle County
CCHS - Lancaster Community Program (BCI)	HIV Specialty	43	New Castle County
CCHS - Porter HIV Wellness Clinic	HIV Specialty	91	New Castle County
CCHS - Beautiful Gate	HIV Specialty	17	New Castle County
CCHS - Kent HIV Wellness Clinic	HIV Specialty	168	Kent County
CCHS - Georgetown HIV Wellness Clinic	HIV Specialty	283	Sussex County
Treatment Centers/Clinics Subtotal:			*1,443*
Physicians and Department of Correction			
Drs. Alfred Bacon, David Cohen, Anand Panwalker, John Piper, Stephanie Lee	ID Specialists	200	New Castle County
Dr. Kirsten Hauer	ID Specialist	40	New Castle County
Dr. John Reinhardt	ID Specialist	22	New Castle County
Drs. Marshall Williams, James Ley, Wesley Emmons, Maya Gupta, and NP-C Eileen Williams	ID Specialists	367	New Castle County
Dr. Ramesh Vemulapalli	ID Specialist	60	Kent County
Dr. Scott Olewiler	ID Specialist	46	Sussex County
Dr.Vincenzo Scotto	ID Specialist	40	Sussex County
Dr. Antonio Zarraga	ID Specialist	32	Sussex County
Department of Correction	HIV Specialty	125	Statewide
Physicians and Department of Correction Subtotal:			*932*
Treatment Centers/Clinics and Physicians/Department of Correction Grand Total			*2375*

Evaluation of the CCHS HIV Program indicates that it has a high patient to provider ratio (number of total patients compared to the number of physicians and nurse practitioners). For instance, at one time Montefiore Medical Center in New York had an active patient census of 1,700 and a staff of 25 medical providers (ratio of 68:1). Johns Hopkins in Baltimore had a patient population of 2,500 patients and a staff of 50 medical providers (ratio 50:1). The

CCHS HIV Program has an active census of 1,393 with a total of 8.7 FTE providers, which is a ratio of 160:1. The national benchmark standard is a ratio of 75:1. Despite these ratios, the clinical outcome measures achieved by the CCHS HIV Program staff are among the best in the nation (90% of the patient population is on HAART and 81% of those have undetectable viral loads). Adherence to clinical visits is 85%, with a yearly lost to follow-up rate of 11%. Mortality rate in 2007 was 2.5%. Important information is evident when an analysis is conducted per county, as summarized in the following table.

Table 12: CCHS HIV Clinics Patient to Provider Ratio, 2008

	New Castle County	Kent County	Sussex County
Number of patients	886	187	320
Number of providers	5	1.5	2.2
Ratio	***177:1***	***125:1***	***145:1***

Qualifications for Providers Who Care for Patients with HIV Infection

Multiple studies have demonstrated that better outcomes are achieved in HIV-infected outpatients cared for by a clinician with HIV expertise, which reflects the complexity of HIV infection and its treatment. Thus, appropriate training and experience, as well as ongoing continuing medical education (CME), are important components for optimal care. Primary care providers without HIV experience, such as those who provide service in rural or underserved areas, should identify experts in the region who will provide consultation when needed (DHHS Guidelines, Nov. 3, 2008).

Currently there is no national standard for identifying an HIV expert. Multiple HIV specific associations provide definitions of an HIV Specialist/Expert. These associations include the following: the HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America (IDSA), the American Academy of HIV Medicine (AAHIVM), and the Association of Nurses in AIDS Care (ANAC).

In defining HIV-qualified physicians, one must take into account both the training and expertise of the adult and pediatric infectious disease specialists, as well as the expertise and experience of physicians from a variety of medical disciplines who have made a significant professional commitment to HIV/AIDS care and who care for tens of thousands of patients with HIV disease.

The HIV Medical Association (HIVMA)

HIVMA believes that an HIV-qualified physician should manage the care of patients with HIV disease. There is ample evidence in the research literature that care by experienced HIV providers translates into improved clinical outcomes. HIVMA proposes that any credentialing process to identify HIV-qualified physicians be based on a combination of patient experience and the demonstration of on-going education and training in HIV care, especially in the area of antiretroviral therapy. To be an HIV-qualified physician, an individual should be able to show continuous professional development by meeting the following qualifications:

- In the immediately preceding 24 months has provided continuous and direct medical care to a minimum of 20 patients who are infected with HIV; and
- In the immediately preceding 24 months has successfully completed a minimum of 30 hours of Category 1 continuing medical education in the diagnosis and treatment of HIV infected patients; or

- Re-certification in the subspecialty of infectious diseases or initial board certification in infectious disease in the preceding 12 months.
- In the absence of a primary medical care provider meeting these criteria in a given community, an established consultative relationship between a primary care provider and at least one HIV expert is a viable alternative.

The American Academy of HIV Medicine (AAHIVM)

The AAHIVM's definition of a HIV Specialist incorporates continuing medical education (CME) units and clinical experience and also requires frontline providers that wish to be considered as HIV Specialists to meet these qualifications on a recurrent basis. In addition, the Academy's definition uniquely incorporates a component for external validation through an HIV Medicine Credentialing Examination. This exam is offered to physicians (MD, DO) physician assistants (PA) and nurse practitioners (NP). States such as New York and California are beginning to offer the AAHIVM credentialing process as one option for identifying physicians as "HIV Specialist". Credentialing requirements must be met every two years:

- Experience
  - Maintain current and valid MD, DO, PA, or NP state licensure
  - Provide direct, continuous, ongoing care for at least 20 HIV patients over the past two years
- Education
  - Complete at least 30 hours of HIV-related CME category 1 credits over the past two years.
- External Experience
  - Successfully complete the AAHIVM Medicine Credentialing Examination.

The Association of Nurses in AIDS Care (ANAC)

ANAC and the HIV/AIDS Nursing Certification Board (HANCB) endorse the concept of voluntary periodic certification by examination for all nurses in HIV/AIDS nursing. Certification is one part of a process called credentialing. It focuses specifically on the individual and is an indication of current competence in a specialized area of practice. Board certification in HIV/AIDS nursing is highly valued and provides formal recognition of HIV/AIDS nursing knowledge. In addition to the AIDS Certified RN (ACRN) exam, there is also an Advanced ACRN for Nurse Practitioners (AACRN).

ACRN and AACRN certification requires re-certification every four years:

- For eligibility, a member must:
  - Be currently licensed as a registered nurse in the United States or the international equivalent (At the time of application, a member must be in good standing and not suspended, revoked or under review by any state or district Board of Nursing).
  - Have at least two years experience in clinical practice, education, management, or research related to HIV/AIDS nursing is recommended.
  - Complete and file an application for the examination.
- For renewal, a member must:
  - Obtain a total of 70 continuing education (CE) credits, which are required for re-certification every four years. At least 50% of the CEs must be in HIV/AIDS nursing care.

New Enrollees in Primary Medical Care – Data From the HIV Wellness Clinics

Table 13 below shows that except for Porter/BGOC/Lancaster, at least half of the patients who report for the first time for treatment at an HIV Wellness Clinic are AIDS-defined. This implies a huge "Unmet Need"—clients that know their HIV status but are not in care, as verified in the "Lost to Care" figures presented on pages 81 through 85.

Table 13: New Clinic Clients (Presenting for the First Time With an AIDS Diagnosis) as of November 2008

Characteristic of New Enrollee	Clients Presenting with an AIDS Diagnosis on the First Appointment at an HIV Wellness Clinic as of 11/08			
	Wilmington	Porter/BGOC/ Lancaster	Smyrna	Georgetown
New Patients	65	18	31	33
% AIDS defined	50%	22%	50%	66%
% New to Care	54%	80%	71%	31%

At this time, a SPNS proposal is being completed, the goal of which is to create better linkages for African American women with late entry into care.

Primary Medical Care in Prison

Medical care provided within the prison system is provided through a contractual arrangement between the Department of Correction and Correctional Medical Systems (CMS). CMS is able to provide evaluation and treatment of the incarcerated individual at all correctional facilities statewide. HIV treatment is available at the State Correctional Facilities. Public Health Department (PHD) treatment guidelines are the current guidelines being used at all facilities.

Primary Medical Care and Adolescents

HIV medical care for adolescents is provided through collaboration between the Christiana Care HIV Program and A. I. DuPont Pediatric Infectious Disease Clinic. Adolescents are enrolled into the Ryan White Part D Program at either site. Though there are some exceptions, adolescents under the age of 19 are managed at A.I. DuPont while those 19 years of age and older are transitioned to one of CCHS's adult HIV clinics. Adolescent surveys are administered under the Ryan White Part D program upon enrollment and every six months to identify barriers to care for this population. In addition, linkage into care is enhanced through collaboration with school-based wellness centers and juvenile correction centers. Current numbers do not support the establishment of an adolescent-only HIV clinic.

b. HIV-Related Medicines

As stated on page 64, there is no waiting list among ADAP clients in Delaware for AIDS medications. In FY 2007, 637 unduplicated clients utilized an average of $4,429 in ADAP funds.

c. Mental Health

Historically, there has been a working group evaluating the existing activities between the Division of Public Health (DPH) and the Division of Substance Abuse and Mental Health (DSAMH). This group is venturing to provide linkages and support to current systems, which are struggling to meet the needs of the HIV-infected client. In a 2006 Consumer Survey and a 2008 Provider Perspective Survey, mental health services ranked in the top six "Most Needed Services". It has been noted on page 70 that critical funding for mental

health services has been discontinued for programs in Kent and Sussex Counties, resulting in a significant gap in services.

Outpatient psychiatric/psychological testing and crisis intervention is available within the structure of the existing community mental health clinics. Additionally, Medicaid provides outpatient mental health services to AIDS Waiver clients.

Ryan White Part B and Part C funds are available for outpatient services but are restrictive in scope. In FY 2008, 12 clients received mental health counseling through contracts with the Delaware HIV Consortium. At the present time, there are 15 contracted mental health providers in the state. Through Ryan White Part C, 166 clients accessed care through Pathways, an outpatient mental health assessment and treatment program based at Wilmington Hospital. This program provides an excellent linkage to the HIV Program's New Castle County sites at the Wilmington Hospital Annex and Porter State Service Center, with coordination of referrals and care. However, all of the clients accessing care through the Pathways program live in New Castle County. There is a distinct lack of access for clients in Kent and Sussex Counties, as already outlined on page 70.

Regarding health treatment in the Correctional Facilities, mental health assessment and treatment is provided by Correctional Medical Systems (CMS) within Delaware's correctional institutions. On intake, or any time during incarceration, an offender may be referred to the mental health program. The number of inmates requiring evaluation and treatment for stress and other mental health disorders continues to increase. As a result, offenders are often prescribed mental health medications to correct their behaviors. There is also a behavioral program to assist in the long-term behavioral change model.

There is still a need for inpatient and outpatient psychiatric services to address the mental health needs of clients—both for crisis intervention and long-term management of psychiatric disorders. The need continues as well for more traditional services, such as bereavement counseling, support groups, and peer counseling/education.

d. Substance Abuse

In July 2001, the DSAMH funded comprehensive outpatient treatment programs that are required to provide HIV/AIDS early intervention services to all clients either through the outpatient program or through collaborations with other qualified agencies. Each provider must directly provide, or have a contract to provide for, mandatory HIV education and voluntary HIV counseling and testing. This requirement will incorporate much needed prevention and early intervention activities into these treatment programs. Community Education Center is the company under contract to provide substance abuse treatment within the Delaware Correctional System. Inpatient, outpatient and post release treatment services are available, and utilization of these services is often mandated by the correctional system itself.

e. Oral Health Services

The number of Ryan White dental providers decreased from 39 in FY 2004 to 16 in FY 2008—a 58% percent drop in the midst of increasing client enrollment in the program. Furthermore, this number can be misleading. It includes providers who care for numerous HIV infected patients as well as providers who care for few HIV infected patients. Statewide, the current capacity level for dental services continues to be inadequate.

Dental services are offered through private dentistry practices, the Wilmington Hospital Health Center Dental Services and the Delaware Technical Community College Dental Clinic. Ryan White Part C pays for evaluation of patients who access care at the Wilmington Health Services with acute dental problems. They are enrolled into the dental program at the Wilmington Hospital for intervention. In cases where the dental problem is not acute, the patients may be referred to the Delaware Technical Community College Dental Clinic for routine care. Ryan White Part B primarily reimburses for preventative and acute dental services at a fee-for-service basis.

The cost of providing dental care for HIV infected patients through private dentists has increased dramatically. Ryan White dental expenditure has increased by 28%, from $233,247 during the Ryan White grant year 2004 to $321,288 in Ryan White grant year 2007. The number of clients also increased at a similar rate, rising from 526 in FY 2004 to 729 in FY 2007: a 27% increase. Anecdotal data suggests that clients entering the Ryan White dental program tend to have a history of poor oral hygiene. As a result, they require more extensive dental treatment.

Accessing dental care continues to be a challenge for persons living with HIV/AIDS:

- Clients often must wait for up to six months to access dental care for both screening and acute intervention.
- Clients must deal with limited scheduling opportunities compounded with the reality of several dental practices not accepting new patients.
- Clients must get themselves to the physical location of the dental offices, which in most cases is separate from the site where they receive primary medical care.
- Patients do not engage in preventive dental care as required.
- Ryan White dental providers continue to threaten withdrawal of this crucial service to the program's clients. One of the reasons includes failure by case managers to communicate dental referrals to the Ryan White Part B grantee as per the standing operating procedures. This means that the clients are not enrolled in the program's dental program and thus their dental bills cannot be honored for payment. The program cannot verify (especially to auditors) that these are bona fide clients. The providers are compelled to write off the charges and consequently become reluctant accepting future referrals of Ryan White clients.

As the epidemic shifts to traditionally underserved populations, it becomes even more critical that access to treatment is ensured. The need to recruit additional dental providers continues to be a priority.

f. Case management

There is an existing system of HIV/AIDS case management in Delaware, incorporating case managers from the DPH and from Community Based Organizations (CBOs). The system is funded by several different sources, including the Ryan White Program (Part B), Medicaid (through its AIDS Waiver Program) and private dollars.

Between 2001 and 2004, Delaware's HIV/AIDS case management system underwent a profound paradigm shift, moving away from a hospice care model to an empowerment model. In 2008, another shift began to occur, as Delaware's system moved to a medical case management model, which should take approximately two years to implement. There were other significant changes to the system, most notably the introduction of the AIDS Drug Assistance Program (ADAP) direct card system. This reduced the need of some client-case manager contacts. Since 2005, reimbursement for community based case management

agencies has been dependent on the amount of services provided, with the cost of a unit of service (one minute of case manager-client contact) determined at the time of contract negotiations. The contact can be face-to-face or by phone. This fee-for-service arrangement was instituted as one of Delaware's cost containment measures for the Ryan White Program. It is anticipated that Delaware's Medicaid AIDS Waiver Program may make a similar move before the end of the decade.

While these numbers represent the vast majority of persons receiving HIV/AIDS case management in Delaware, there are persons who receive this type of service in other settings. CCHS funds Alfred I. DuPont Hospital for Children to offer pediatric case management (to HIV-infected youth under the age of 18) through its Ryan White Program Part D grant. The Delaware Department of Correction provides short-term case management to HIV-infected persons transitioning out of correctional settings, funded through a contract from DPH. These persons may or may not be included in the caseloads reported through the mainstream programs. In addition, social workers at CCHS provide referrals to appropriate HIV services for a small number of patients who may not have a regular HIV/AIDS services case manager.

Table 14: HIV/AIDS Case Management Caseloads in Delaware – December 2008

Program	Non-Waiver	Waiver	Total	# Of FTE's
AIDS Delaware - NCC	80	149	229	5.25
Brandywine Counseling - NCC	68	35	103	3
Case Management Services	55	85	140	3
Connections CSP, Inc. - NCC	22	10	32	.75
DPH - Limestone	45	70	115	5.5
Total NCC:	270	349	619	17.5
AIDS Delaware - Kent	5	3	8	.25
Connections CSP, Inc. - Kent	6	0	6	.25
DPH - Milford	35	33	68	2
KSCS - Kent	34	54	88	3
Total Kent:	80	90	170	5.5
AIDS Delaware - Sussex	47	33	80	2
Brandywine Counseling - Sussex	0	1	1	.25
DPH - Georgetown	36	27	63	2
KSCS - Sussex	74	87	161	4
Total Sussex:	157	148	305	8.25
Grand Total Statewide:	507	587	1,094	31.25

Notes:

- *Caseload data for community-based programs reflects program utilization as of November 30, 2008.*
- *Caseload data for Public Health programs was reported by DPH program staff during telephone interviews on December 22, 2008 – January 5, 2009.*

These numbers do not include persons receiving non-HIV specific case management (such as through the Veterans Administration) or through the Ryan White Part D Program.

2. Other Supportive Services

From the start, Ryan White Title II (now Part B) dollars have funded a variety of supportive services for persons living with HIV/AIDS in Delaware. The services funded each year vary, based on the amount of available funding, the utilization of the programs by clients, the recommendations for services as made by the Delaware HIV Planning Council), and the changing needs resulting from the ever-changing HIV/AIDS epidemic in Delaware. In previous years,

Ryan White Title II has funded complementary therapies such as chiropractic care, acupuncture and therapeutic massage. During the period 1997 - 2002, Ryan White Title II provided financial support for Patient Education through a series of Resource Centers for persons with HIV/AIDS. Each of these services had merit. However, the Ryan White Title II Program discontinued funding them when other, more critical, services were needed.

In 2008, the Delaware HIV Consortium funded the following services with Ryan White Part B dollars: financial assistance, food, transportation, HIV patient education, mental wellness counseling, nutritional counseling, health insurance continuation, and housing. In a similar way, the Consortium pays for HIV/AIDS Case Management with Part B dollars. However, since the Health Resources and Services Administration considers it as a core service, case management programming will not be included in this discussion of supportive services.

This year Delaware allocated $1,081,190 to fund the eight supportive services listed above. Thirty percent of that amount goes to one service category: housing. Stable housing is a critical need for all persons, but even more so for persons living with HIV disease. There is a direct correlation between the stability of client housing and the client's ability to participate effectively in his or her medical treatment. The 2003 Needs Assessment by the Treatment Services Committee of the Delaware HIV Consortium prioritized housing assistance as the most important unmet need faced by persons living with HIV disease.

In all, funding for the eight supportive services account for less than 10% of Delaware's total Ryan White award. However, these dollars have a significant impact on the lives and health of the persons living with HIV/AIDS.

The continuum of HIV/AIDS supportive services has been provided through five key community-based organizations. They are:

- AIDS Delaware – AIDS Delaware is the state's largest AIDS Service Organization. It has offices in all three of Delaware's counties.
- Catholic Charities – Catholic Charities has a location in north Wilmington, which serves clients with emergency financial assistance, bus tickets, clothing and furniture.
- Delaware HIV Consortium – The Consortium operates a rental voucher program that provides monthly assistance to persons living with HIV/AIDS. This program is the largest HOPWA-funded program in the state of Delaware, and it has been cited nationally as a model program.
- Kent/Sussex Counseling Services (KSCS) – At its primary location in Dover, KSCS offers HIV services nested in a methadone clinic setting. It also offers case management services through two Sussex county sites (Georgetown and Laurel).
- Sussex County AIDS Council (SCAC) – SCAC is an AIDS Service Organization serving the lower portion of Delaware. It is well known for its fundraising and community support, which provides private resources for a generous financial assistance program. It also operates a transportation program that uses volunteer drivers to take patients to medical appointments. This program has closed in June 2009. DPH will conduct a Request for Proposal for a new service provider to continue the program's needed services..

Other community-based organizations that provide supportive services for persons include the Beautiful Gate Outreach Center in Wilmington (early intervention) and the Ministry of Caring (food, housing).

3. HIV Prevention
   The current HIV Prevention needs assessment can be found on pages 52 through 56.

K. Unmet Need Estimate/Lost to Care

In October 2008, DPH analyzed HIV Surveillance data to determine the number of known HIV positive clients who are currently not in care—the population of HIV-infected people that may have unmet case management and treatment needs. The estimated number of known HIV positive clients currently lost to care is 964. Additional cost to Ryan White for these clients is estimated to cost $2.6 million to $4.4 million.

Data Sources/Methodology

Data sources used include the DPH Epidemiological Report and monthly surveillance reports which are, in turn, based on the Evaluation HIV/AIDS Reporting System (EHARS), and on the Ryan White Program and the CCHS service databases. The methodology provided on the website of the HRSA-HIV AIDS Bureau, Institute of Health Policy Studies was used for this study (Kahn, Janney, and Franks-2003). The analysis period covered October 2007 to September 2008. The approach was to identify those who had not received HIV treatment in the past 12 months—i.e., an HIV test, a viral load test, or a CD-4 assessment.

Table 16: Estimated Lost to Care – October 2008

3458	**Number of people living with HIV/AIDS in Delaware as of September 30, 2008**
-1782	Clients (including prison inmates) that had a recorded instance of HIV-related medical testing in EHARS
-39	Clients that had a recorded instance of HIV-related medical testing in the Delaware Electronic Reporting and Surveillance System but not EHARS
-344	Clients that received medication via RW AIDS Drug Assistance Program (ADAP)
-169	Clients that were in care at Christiana Care Health System (CCHS) but had not already been counted in the ADAP group above
-63	Clients known to be in care at a reporting private infectious disease treatment center
-66	Clients known to be in care at Veterans Affairs or long term care hospitals
-31	Clients that died and were recorded in the Delaware Death Registry
964	**Estimated number of known HIV positive clients currently lost to care (28%)**

Unknown factors included the following:

- There may be HIV positive clients that are in care but had no HIV-related medical testing in the past 12 months or had testing that the performing laboratory did not report to DPH as required by Delaware Statute. (Note: A recent HIV Surveillance study revealed only 10 known cases in the last year that were not properly reported, down from 30 cases in a 2006 audit.)
- Some clients that live in Delaware may access HIV care in neighboring states or jurisdictions (e.g. Philadelphia, Baltimore, or Washington DC) and, for a variety of reasons, other states are reluctant to share the names of HIV positive clients with other jurisdictions.
- DPH may have incomplete client lists from private providers.
- Some clients may have moved to another state.

Potential Approaches to Reconnect Clients to Care

1. Send a "generic" letter to the client's last known address to invite him/her to reconnect with care and/or participate in a survey assessing barriers to care.
   a. If funds allow, an incentive could be offered to the client for completing the survey.

b. Resources could be maximized with coordination between CCHS and the Delaware HIV Consortium.
c. Mailed survey return rates are very low.

2. Contract community outreach services to contact clients directly, using DPH demographic information to locate clients who remain in the same general area.
3. Search all other DPH/DSAMH databases to determine if the client is accessing any other DPH service and make contact at the point of service.
4. Use press release or Public Service Announcement asking HIV positive people to seek care.

Cost of Reconnecting Clients to Care

- Based on financial data available in the Ryan White database, the estimated cost to the Ran White Program for each HIV positive client reconnected to care is $2,733-$4,618/year.
- The estimated annual cost to the Ryan White Program of returning all 964 HIV positive clients to care is $2.6M to $4.4M, depending on the type of care provided—e.g. dental, insurance, etc.
- These estimates do not include potential expenses for additional staff needed to provide care for re-entered clients. These costs are shared by Ryan White, CCHS, and other private providers.

Table 17: Average Cost to Ryan White/Client/Year for 964 Clients Lost to Care

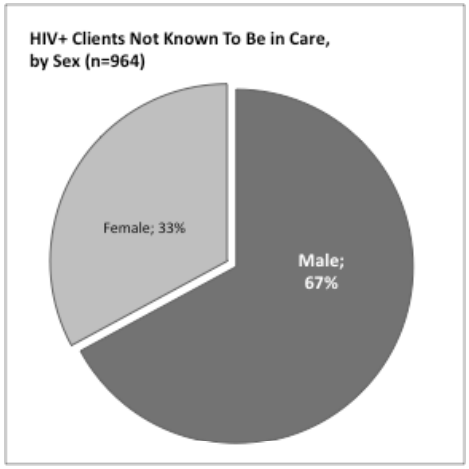
Services	Total Cost	# Clients	Amount Per Client Per Year	Cost for Additional 964 Clients
Dental Individual	$321,288.75	808	$397.63	$383,315.32
Direct State Service	$40,444.19	221	$183.01	$176,421.64
Drugs Individual	$1,861,964.31	865	$2,152.56	$2,075,067.84
Sub-Total 1	**$2,223,697.25**		**$2,733.20**	**$2,634,804.80**

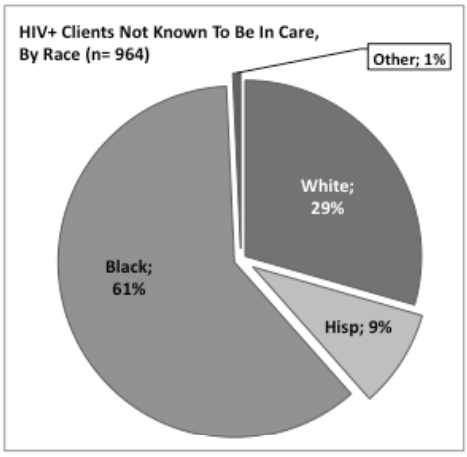
Services	Total Cost	# Clients	Amount Per Client Per Year	Cost for Additional 964 Clients
Consortium	$687,408.50	1255	$547.74	$528,021.36
Insurance	$108,349.99	81	$1,337.65	$1,289,494.60
Sub-Total 2	**$795,758.49**		**$1,885.39**	**$1,817,515.96**

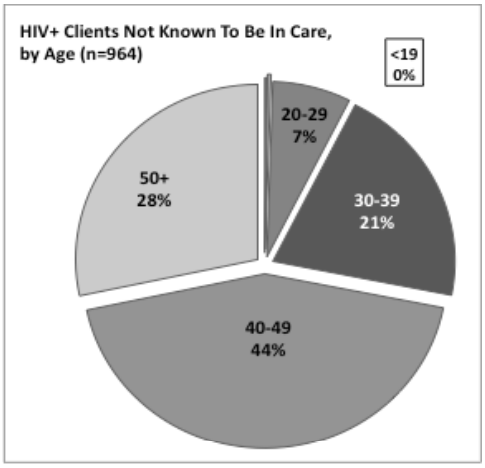
Source: Ryan White Database (4-01-07 – 3/31/08)

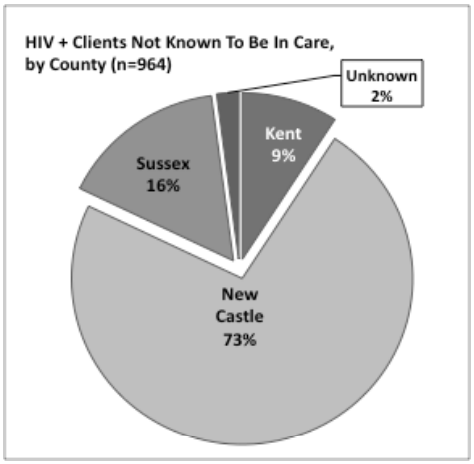
The total cost to Ryan White for an additional 964 clients is $2,634,805 to $4,452,321/year.

Chart 18: Demographics of 964 Clients Lost to Care









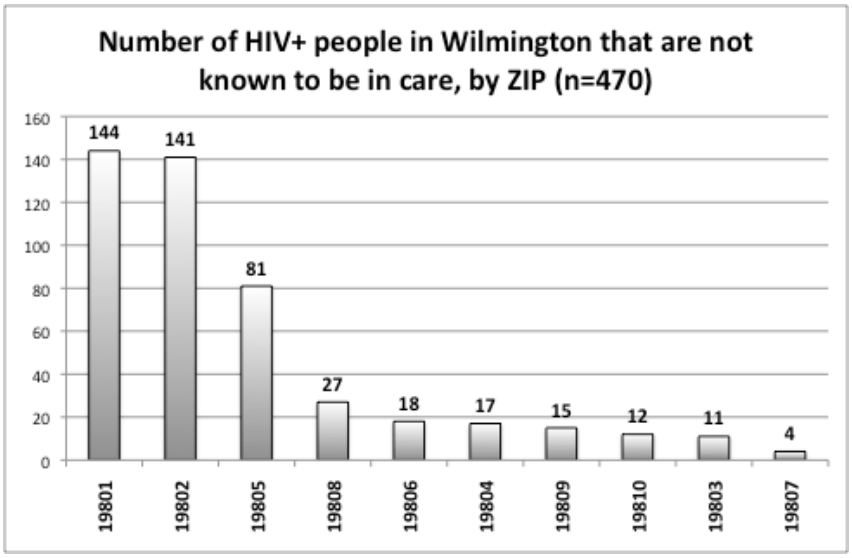


Chart 19: Clients Lost to Care in Wilmington

78% (366/470) of HIV+ people living in Wilmington and not known to be in care reside in 19801, 19802, and 19805

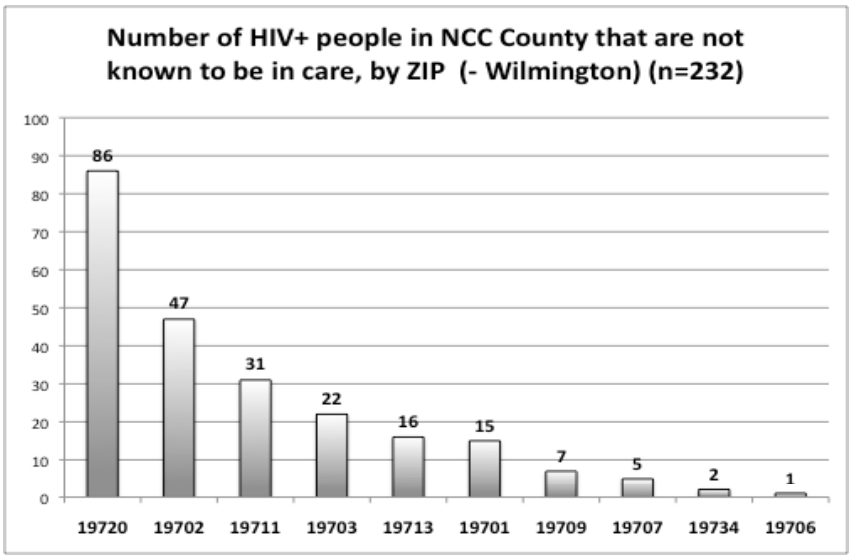


Chart 20: Clients Lost to Care in New Castle County Outside of the City of Wilmington

95% (670/702) of all HIV+ people living in New Castle and not known to be in care reside in Wilmington ZIP codes.

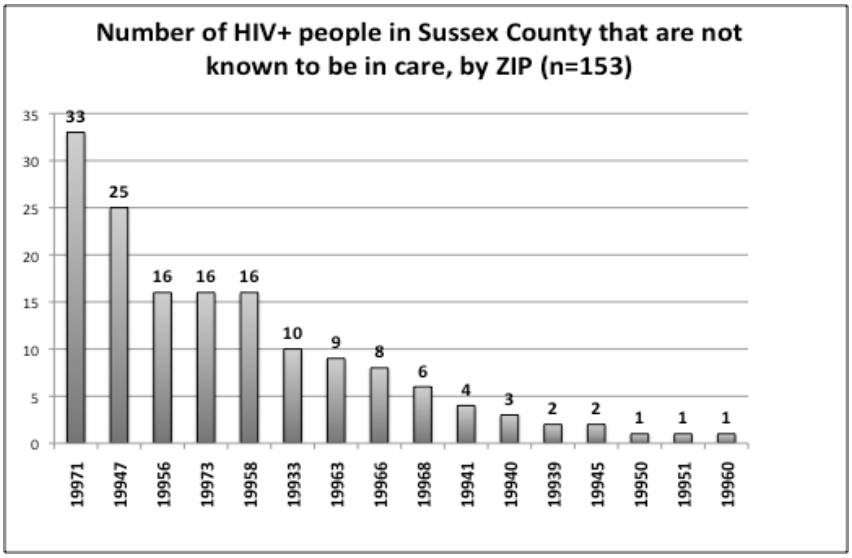


Chart 21: Clients Lost to Care in Sussex County

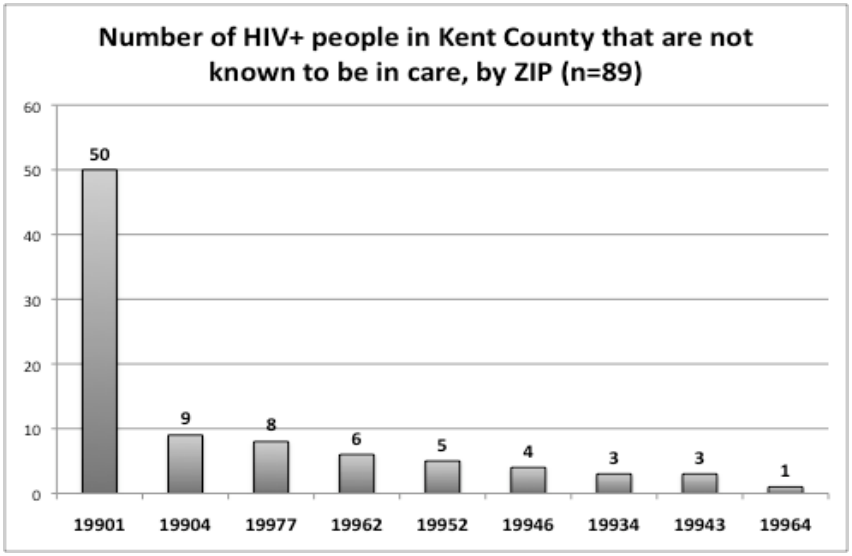


Chart 22: Clients Lost to Care in Kent County

Throughout the HIV/STD program, DPH targets individuals who know they are HIV infected yet not in care. Working collaboratively, disease intervention staff from the STD clinics interacts with the HIV counseling and testing staff at confidential testing sites. Clients identified who are HIV positive are referred for treatment and partner notification services to DIS staff.

The HIV/AIDS surveillance team and the nurse liaison work with all reporting physicians to ensure newly diagnosed HIV positive people are referred to appropriate and needed services. Referrals are made for substance abuse treatment, partner notification, case management and HIV/AIDS treatment. CCHS staff places special emphasis on following clients who miss appointments on a regular basis.

L. Elimination of Disparities in Access to, and Services for, Historically Underserved Populations

- CCHS Georgetown clinic staff work with migrant health centers and poultry plants to find people who have missed appointments or are at risk of HIV infection.
- Sussex County reaches out to HIV infected migrant health workers and refers them into care.
- The bilingual staff in the CCHS clinic system reach out to HIV-infected Hispanic population statewide.
- Latin American Community Center staff offer outreach, counseling and testing, prevention education, non-HIV specific case management, substance abuse counseling, and other supportive services primarily to Hispanic residents of Wilmington, as well as those living in several other areas of New Castle County with Hispanic populations (i.e., areas of New Castle and Newark).
- The 2009-2011 Resource Guide includes additional information in Spanish.
- CCHS staff also educate family planning clinics about HIV counseling and testing procedures.
- Targeted outreach and counseling and testing is offered to minorities in the City of Wilmington.
- There is one State recognized Native American Indian Tribe in Delaware—the Nanticoke Indian Tribe. In an effort to bring its members into the fold and include them in addressing HIV/AIDS issues, informal discussions with some of the current members in this group will be conducted. Although recognized by the State in 1922, clear tribal re-organization didn't occur until 1977. An annual Pow Wow is held each fall, which is its only publicized activity.
- Recently, the Delaware HIV Consortium collaborated with CCHS on a SPNS application to recruit African American women lost to care in the City of Wilmington into HIV medical treatment and to retain them in care.
- The Department of Correction offers all incoming high-risk inmates HIV testing upon intake and provides transitional case management and support groups for this underserved population.

SECTION II: DESCRIPTION OF THE CURRENT CONTINUUM OF CARE

The following tables contain a resource inventory of organization and individuals providing the full spectrum of HIV services accessible to people living with HIV in the state by service category.

Table 23: Clinics/Physicians that Provide HIV Primary Medical Care (December 2008)

Clinic or Physician Name	Practice Type	Area of Service
A. I. DuPont Hospital for Children	HIV Specialty	Statewide
Veterans Affairs Medical Center	HIV Specialty	Statewide
CCHS - Wilmington Hospital Annex	HIV Specialty	New Castle County
CCHS - Lancaster Community Program (BCI)	HIV Specialty	New Castle County
CCHS - Porter HIV Wellness Clinic	HIV Specialty	New Castle County
CCHS – Beautiful Gate	HIV Specialty	New Castle County
CCHS - Kent HIV Wellness Clinic	HIV Specialty	Kent County
CCHS - Georgetown HIV Wellness Clinic	HIV Specialty	Sussex County
Drs. Alfred Bacon, David Cohen, Anand Panwalker, John Piper, Stephanie Lee	ID Specialists	New Castle County
Dr. Kirsten Hauer	ID Specialist	New Castle County
Dr. John Reinhardt	ID Specialist	New Castle County
Drs. Marshall Williams, James Ley, Wesley Emmons, Maya Gupta, NP-C Eileen Williams	ID Specialists	New Castle County
Dr. Ramesh Vemulapalli	ID Specialist	Kent County
Dr. Scott Oleweiller	ID Specialist	Sussex County
Dr. Vincenzo Scotto	ID Specialist	Sussex County
Dr. Antonio Zarraga	ID Specialist	Sussex County
Delaware Department of Correction	HIV Specialty	Statewide

Table 24: Organizations Offering HIV/AIDS Case Management Services (December 2008)

Organization	Office Location	Area of Service
AIDS Delaware	Wilmington	New Castle County
AIDS Delaware	Smyrna	Kent County
AIDS Delaware	Rehoboth Beach	Sussex County
Alfred I. DuPont Hospital for Children	Wilmington	Statewide
Brandywine Counseling, Inc.	Georgetown	Sussex County
Brandywine Counseling, Inc.	Wilmington	New Castle County
Case Management Services, Inc.	Wilmington	New Castle County
CCHS – Wilmington Hospital Annex	Wilmington	New Castle County
CCHS - Lancaster Community Program (BCI)	Wilmington	New Castle County
CCHS – Beautiful Gate	Wilmington	New Castle County
CCHS – Porter HIV Wellness Clinic	Wilmington	New Castle County
CCHS – Kent HIV Wellness Clinic	Smyrna	Kent County
CCHS – Georgetown HIV Wellness Clinic	Georgetown	Sussex County
Connections CSP, Inc.	Dover	Kent County
Connections CSP, Inc.	Wilmington	New Castle County
Delaware Department of Correction	Wilmington	Statewide
Division of Public Health – Milford	Milford	Kent County
Division of Public Health – Georgetown	Georgetown	Sussex County
Kent/Sussex Counseling Services – Dover	Dover	Kent County
Kent/Sussex Counseling Services – Georgetown	Georgetown	Sussex County
Kent/Sussex Counseling Services – Laurel	Laurel	Sussex County

**HIV case management services at Christiana Care HIV Wellness clinic sites include Part D and other limited case management services.*

Table 25: Organizations Licensed as Mental Health and/or Substance Abuse Counseling Treatment Providers (December 2008)

Agency	Locations/Service Areas
1212 Corporation	Wilmington
Adult Rehabilitation Center of the Salvation Army	Wilmington
Advanced Treatment Systems	Claymont
Aquila of Delaware	Wilmington, Georgetown
Brandywine Counseling, Inc.	New Castle County, Sussex County
Brandywine Program	Newport
Catholic Charities	Wilmington
Children & Families First	New Castle County, Kent County
Community Education Center (DOC Programs)	Dover, Georgetown, Smyrna, New Castle, Wilmington
Community Mental Health Center	Wilmington, New Castle County, Dover, Sussex County
Connections CSP, Inc.	Dover, Newark, Middletown, Wilm., Townsend, DE City
Crisis Intervention Services	New Castle County
Crossroads of Delaware	Wilmington
Daybreak Counseling Services (Pastoral)	Milford
Dover Behavioral Health System	Dove
Kent/Sussex Detoxification Center	Ellendale
Fellowship Health Resources	Georgetown, Ellendale, Milford, Milton
Gateway Foundation	Delaware City
Gaudenzia, Inc.	Newark, New Castle County
Hogar CREA International, Inc. of Delaware	Wilmington
Horizon House (Hudson Health Services, Inc.)	Wilmington
Hudson Health Services Inc.: Tau House (ANKH)	Georgetown
Hudson Health Services Inc.: Corinthian House	Georgetown
Kent County Day Treatment	Dover
Kent Sussex Counseling Services	Dover, Kent County, Sussex County
Kent/Sussex Detoxification Center	Kent County, Sussex County
Kent/Sussex Mobile Crisis Unit	Kent County, Sussex County
Kirkwood Detoxification Center	Wilmington
Latin American Community Center	Wilmington
Limen House, Inc.	Wilmington
Middletown Counseling Services	Middletown
Open Door/Holcomb Behavioral Health Systems	Dover, Newark, Claymont
PACE, Inc.	Wilmington
People's Place	Smyrna, Milford
Phoenix Mental Health / Pathways	Dover, Lewes, New Castle, Seaford
Psychotherapeutic Service, Inc.	New Castle County, Dover, Millsboro
Resources for Human Development	Wilmington
Serenity Place, Inc.	Dover
SODAT-Delaware, Inc.	Wilmington
Sussex County Day Treatment (children/families)	Lewes
Thresholds, Inc.	Georgetown

SECTION III: NEEDS, BARRIERS, AND GAPS IN SERVICES

From 2006 through 2008, the Planning Council conducted four surveys to evaluate client needs, services met, and barriers to services, and a Gaps Analysis of responses was performed. PLWHA, providers and the general public took part in the various surveys, as described below and on pages 8 to 9.

- 2006 Agency Capacity and Capability Survey: This survey gathered data on 59 of 150 agencies sent the survey and their services.
- 2006 Consumer Survey: This survey gathered information from 278 clients individually interviewed about services, needs, and barriers to services.
- 2008 Provider Perspective Survey: This survey asked the same client questions of providers, except from their perspectives.
- 2008 Prevention/At Risk Survey: This survey was made available to the public to assess risk.
- 2008 Gaps Analysis: Survey responses were compared and analyzed in the 2008 Gaps Analysis and findings are identified below.

A. Met Services

From a listing of medical and supportive services listed in the 2006 Consumer Survey and the 2008 Provider Perspective Survey, both clients and providers ranked the same five core medical services as the highest "Met" services, in slightly different orders, as listed to the right.

Met Services

HIV Medical Care
HIV Case Management
General Medical Care
Eye Care
Help Paying for HIV Medications

B. Unmet Services

Clients and providers also ranked "Unmet" services, combining medical and supportive services in the rankings. The rankings were substantially different, however, with clients ranking more medical services as the highest "Unmet" services in 2006, while providers ranked more supportive services as "Unmet" by 2008. Differences in ranking could be attributed to DPH's prioritization of, and new funding for, more core medical services, including prescription payment services, which were started or better marketed after the Consumer Survey was conducted in 2006. As a result, providers viewed "Unmet" services differently two years later when the 2008 Provider Perspective Survey was conducted. Despite the varying orders, both groups considered the services above "Unmet".

Unmet Services

Dental Care	Eye Care
Help Paying Household Bills	Vocational Assistance
Help Paying for Other Medications	Alternative Therapies
Help Paying for HIV Medications	Exercise Facilities
Help Finding Affordable Housing	Transportation to Non-Medical Appointments

C. Most Needed Medical Services

Clients and providers ranked the same eight medical services at the right as "Most Needed" but in different order.

Most Needed Medical Services

HIV Medical Care	General Medical Care
Dental Care	Mental Health Service
Eye Care	Help Paying for Other Medicines
Help Paying for HIV Medicines	Drug/Alcohol Services

D. Most Needed Supportive Services

Both clients and providers ranked the same four supportive services as "Most Needed" but in different order, with two other services ranking high for each of the groups.

Most Needed Supportive Services

HIV Case Management	Help Finding Affordable Housing
Help Paying for Household Bills	Food Programs
Transportation to Medical and Non-Medical Appointments	

E. Barriers to Services: Cross System and Survey Identified

Barriers noted below include various perspectives (of PLWHA, providers, and staff), policy/regulatory issues, infrastructure constraints, changes to State Medicaid/Medicare programs, and so forth. Some are from the surveys conducted during this planning cycle, while many others were listed in prior plans and remain relevant today.

1. Barriers Identified by PLWHA and Providers in the Surveys

   The following barriers were ranked from high to low depending on the survey responses of PLWHA and providers during the current planning cycle.

#	Barrier
1	Don't Know Where to Find
2	Can't Pay
3	Funding Limitations/Other (Includes Lack of Providers, Not Covered Service, Waiting Lists)
4	Don't Know How to Find
5	Eligibility
6	Transportation
7	Public Apathy, Stigma and Collaboration Among Agencies (combined from 2006 Agency Survey)
8	-New Castle County: Child Care, Interpreter/Translation (including need for Spanish/Russian materials) -Kent and Sussex Counties: Proximity to Other Agencies -All counties: Sign Language (accessibility issues from 2006 Agency Survey)

2. Funding for Services

   Adequate funding is a critical issue in the planning of HIV/AIDS prevention and treatment services. Challenges include the amount of available funding and how that funding can be used.

   - Serving increased numbers of clients with the same amount of money

     During the years 2002 through 2008, funding for HIV treatment services has remained relatively level. Advances in HIV treatment reduced the numbers of patients who die each year from complications of HIV/AIDS. Meanwhile new HIV infections continue to occur. The net result is a greater demand for services for existing patients in the HIV treatment system.

   - A potentially significant influx of new patients in the HIV treatment system

     In recent years, the Centers for Disease Control boosted its counseling, testing and referral activities. As a result, more clients infected with HIV/AIDS have been identified and linked to HIV treatment services earlier in the progression of their HIV disease. Minimal increases or level funding for HIV primary medical care does not provide for additional capacity within the HIV treatment system for these clients, which could result in the erosion of treatment services among high-risk populations if treatment services are inadequate after an HIV positive status is known. Additionally, new initiatives are being evaluated in order to find and re-engage those HIV positive individuals currently lost to care. Funding needs to be available to provide services for them, once they are re-engaged.

   - Less flexibility in the use of federal dollars for HIV treatment services

     The Ryan White Part B award is subject to formulaic restrictions imposed by the federal government, including an "ADAP carve-out" (a mandated percentage of the Part B award that must be used for HIV medications). For several years, Delaware experienced a surplus of

funds in the "ADAP carve-out" because of its good fiscal management of those dollars. Because of the "carve-out", these dollars could not be used to pay for other services critically needed by patients. In addition, the new mandate requiring that 75% of Part B dollars be spent on core medical services makes it more difficult to maintain needed supportive services that improve the health outcomes of HIV primary medical care. These restrictions limit Delaware's flexibility in using its resources to provide the greatest number of services to the greatest number of clients.

- The push for integrated services without the advantages of integrated funding
  Integration of prevention and treatment services is a valid approach to addressing the epidemic and Delaware has integrated services whenever possible. Unfortunately, there is a lack of coordination among the various government entities with an interest in HIV prevention and treatment. The Office of Population Affairs (OPA), CDC, SAMHSA, HRSA and others encourage state-level integration of services, while regularly releasing independent initiatives for similar services to similar target populations. These initiatives actively work against successful integration by demanding that each funding stream be reported as 'silo' programs and requiring different fiscal, evaluation and outcome requirements for each. The burden at the service provider level is the duplicative reporting to multiple funding agencies for a single service or program, which pulls already limited time and money away from service delivery to administrative expenses. At a minimum, federal funding streams should promote and accept a single unified reporting mechanism that does not require artificial (and sometimes arbitrary) dissection of the integrated programs for which they are advocating.

- Funding fluctuations
  Funding fluctuations can have a negative and positive impact on care, depending on the situation.

  a. "Rapid fire initiatives"—a method by which funding is made available quickly for programs and then is not maintained for reasonable periods of time—makes it difficult to sustain programming long enough to demonstrate the efficacy of such programs.

  b. On the other hand, sporadic influxes of additional funding can help in meeting immediate client needs. When that funding is not sustained to cover needs on an on-going basis or to meet higher levels of required services, however, clients are again left without services. For example, significant carry-over funding was approved for dental treatment plans in 2008, but those dollars will be greatly reduced in the coming years. When that occurs, dental needs will emerge again as a significant gap in services.

  These types of funding fluctuations explain the differences in services gaps (pages 89 through 94) that emerge when surveys are conducted over the course of several years. In one year, a need may be met because of the availability of funds. Two years later, the funding has been reduced or additional needs have emerged as clients are re-engaged to services, and the funding is not there to cover the needed services.

3. Lack of Adherence to Medications
   The findings of Delaware's SHAS study, which is included in the 2004 Epi-Profile and includes data from July 1991 to June 30, 2004, found that 320 clients on antiretroviral medications did not take medications continuously due to the following reasons: pill fatigue, adverse drug reactions associated with HIV medications, homelessness and misinformation on HIV medication adherence.

4. Client Co-Payments for Services
   Adherence to HIV treatments is complicated by co-payments associated with Medicaid, private insurance and Part D Medicare. Some clients have to make difficult life choices between paying medication co-payments and meeting other family or personal needs.

5. Stigma
   Clients attending the HIV wellness clinics report that there is still significant stigma in Delaware associated with the disease. More ominously, stigma within the affected communities themselves has created a "positive/negative divide". This is perhaps a more challenging barrier to care. As a result, (1) persons with HIV/AIDS are much more likely to not disclose their status, and (2) they may engage in unsafe behaviors. Ironically, advances in treatment may indirectly contribute to this stigma within affected communities. Years ago there was a more evident compassion as persons with HIV/AIDS had high rates of morbidity and mortality. Today, fear and suspicion often replace compassion, since it is difficult to tell (at least outwardly) if a person is HIV positive.

6. Working and Living With HIV/AIDS
   If AIDS-defined persons experience good health outcomes with their HIV treatment and desire to return to the workforce, they face possible loss of public health insurance coverage (such as the Medicaid AIDS Waiver or Medicaid). Many of these clients are reluctant to take that step in the event that their health deteriorates, leaving them without a job and without health insurance when they need it the most.

7. Staffing Issues
   Anecdotal reports indicate that it is a challenge for service providers to recruit and retain qualified staff (particularly for medical, substance abuse, mental health and case management providers).

8. Loss of Clients to Care Following Release from Incarceration
   The Ryan White Program provides transitional case management to help connect released HIV positive inmates to care in the community. These clients often require several months of medium level case management. Inmates are released with few resources, frequently lacking housing, employment, food and other basic necessities of life. Often they are unable to return to the family homes for temporary support. Adherence to medications and medical appointments is low on the priority list for the newly released inmates. Furthermore, a large number have long-standing substance abuse issues that are not adequately addressed during incarceration and lack skills and resources to avoid relapse when released. Delaware's Department of Corrections (DOC) recently assumed the function of providing transitional case management to newly-released HIV positive inmates (October 1, 2008). Currently, DOC is establishing new systems for this program

F. Gaps in Services Identified From The Surveys

Taking into account survey limitations, new DPH initiatives started since 2006, information provided through the surveys, and additional information supplied by providers, a number of common gaps emerged. These gaps will be even more critical to address in the upcoming years in light of the current economy and its potential negative impact on federal and local funding for HIV services. With that said, the following gaps have been identified in HIV treatment—grouped as Medical Services Gaps, Supportive Services Gaps, and Additional Gaps—as well HIV prevention:

(1) Medical Services Gaps

Currently, the five highest met core medical services appear to receive sufficient funding—HIV Medical Care, HIV Case Management, General Medical Care, Eye Care, and Help Paying for

HIV Medications—a situation that could change if an influx of new patients enter the system. Primary medical services gaps currently are as follows:

Gap #1: *Dental Care* is a high "Unmet" service, despite its being a core medical service and new funding made available for it since 2006, dropping from #1 in 2006 to #5 in 2008. Funding fluctuations, as well as the availability of providers, contribute to the rise and fall of dental care as an "Unmet" service versus a "Met" service.

Gap #2: *Help With Other Medicines* dropped from #5 to #10, but it is still an important component of a client's well-being.

Gap #3: *Mental Health* services were ranked #14 by clients and #10 by providers in terms of services "Unmet" but ranked in the top six of "Most Needed Services by both clients and providers. Funding should continue to be directed to this core medical service which has seen a decline in services available to clients, particularly in Kent and Sussex Counties.

Gap #4: *Alternative Therapies* rose as an "Unmet" service since 2006 according to providers, probably as a result of more funding being directed to core medical services.

Gap #5: *Assistance with Medical Coverage* is not a category under any of the services, per se, but it stands out as a need in that 2% to 10% of clients have no medical insurance at all. Efforts should be made to assist clients to get the appropriate health insurance coverage, based on their income status.

(2) Supportive Services Gaps

Supportive services have a significant impact on persons with HIV/AIDS, for both their mental and physical well-being. Identified gaps in supportive services are as follows:

Gap #1: *Help Finding Affordable Housing* was ranked consistently high an "Unmet" service and a "Need" by clients and providers and will likely continue to remain so, if not worsen, in today's economy. Client income and working statuses highlight this need.

Gap #2: *Help Paying Household Bills* ranked consistently high as an "Unmet" service and a "Need".

Gap #3: *Food programs* were considered the #6 highest "Unmet" need by clients, while providers did not rank it high. With the current economy, support of food services could be an even more critical need in the future; and monitoring of funding for such programs will be vital.

Gap #4: *Transportation to Non-Medical Appointments* rose to #1, as perceived by providers in 2008, particularly in Kent and Sussex Counties.

Gap #5: *Vocational Assistance* would be a valuable tool for a number of clients with HIV/AIDS in Delaware. It was perceived as a high "Unmet" service (#3) by providers but only #9 by clients. Still, 26% of the clients checked themselves as unemployed but able to work, and providers perceived 35% as unemployed but able to work. Vocational assistance would be a substantial benefit to clients' financial and mental well-being.

Gap #6: *Exercise Facilities* rose as an "Unmet" service since 2006 according to providers, probably as a result of more funding being directed to core medical services.

(3) Additional Treatment Gaps

Other treatment gaps identified in discussions with providers are as follows:

Additional Gap #1*: Funding that had been available for integrated treatment for mental illness and substance abuse* is sorely needed. The advocacy model which had been established was working especially well in Kent and Sussex Counties. Lack of funding has ended those services, leaving a severe gap in those services.

Additional Gap #2*:* A *treatment site is needed for the Newark area*. The Newark area contains a cluster of clients lost to care. The establishment of local full-time or satellite clinic in that area might increase the likelihood that residents in the area would seek treatment.

(4) Prevention Gaps: *Lack of educational opportunities*

The Prevention/At-Risk Survey was administered throughout the state at a variety of venues—from classes to community fairs. Questions on the survey revolved around behavior, not services, so gaps in services cannot be named from it. However, of the 803 respondent, 45% responded that they had not been educated about HIV/AIDS in the past 12 months. At the same time, in the past 12 months, 55% had had unprotected sex and 10% had shared needles, among other statistics indicating high risk. Educational opportunities, while not listed as a gap in service, are needed among the general public, and in particular, youth.

Chapter VI outlines strategic and annual goals and objectives, priority recommendations for HIV core and related services, and evaluation methods for meeting those goals and objectives.

SECTION I: STRATEGIC PLAN GOALS AND OBJECTIVES

Continuum of Care for High Quality Core Services and Shared Vision for System Changes

Operational definition of continuum of care and core services

The Health Resources and Services Administration (HRSA) has defined continuum of care as an approach that helps communities plan for and provide a full range of emergency and long-term service resources to address the various needs of PLWHA. To this end, Delaware will strive to achieve the seven goals identified in HRSA's 2005-2010 Strategic Plan:

Goal 1: Improve access to health care
Goal 2: Improve health outcomes
Goal 3: Improve the quality of health care
Goal 4: Eliminate health disparities
Goal 5: Improve the public health and health care systems
Goal 6: Enhance the ability of the health care system to respond to public health emergencies
Goal 7: Achieve excellence in management practices.

Goal 1: Improve Access to Healthcare

Objective 1.1: The state will expand the capacity of the health care safety net by:

- Expanding and/or increasing the number of available access points that provide HIV health care to underserved, vulnerable and special needs populations. Through collaboration with Christiana Care Health System, DPH's HIV Program will work to improve the training and recruitment of Infectious Disease (ID) Specialists for Delaware.
- Increasing the range of services available through access points to include such expanded services as mental health, oral health, substance abuse, co-morbid conditions and preventive services.
- Enhancing and expanding services that address and target populations with particular health needs (e.g. adolescents, pregnant women; immigrants with language and health insurance issues and seniors).

Objective 1.2: The state will promote the development of a culturally diverse and representative health care workforce by:

- Providing training opportunities and technical assistance for existing health care workers to reduce potential barriers to care (e.g. cultural competence; health literacy; limited English proficient clients).
- Facilitating the infusion of cultural competence into HIV service provider trainings.
- Promoting training in cross-cultural communication for providers.

Objective 1.3: The state will promote access to health insurance and maximize use of available reimbursements for health care services by:

- Continuing and expanding enrollment of eligible individuals into Medicaid, DPAP, SCHIP, Medicare and other appropriate health insurance programs.
- Supporting and enhancing ADAP-funded Health Insurance Program to increase access to care by reducing barriers to payment.

Goal 2: Improve Health Outcomes

Objective 2.1: The state will expand the availability of health care, particularly to underserved, vulnerable, and special needs populations by:

- Working with Community Based Organizations to help engage vulnerable population in quality primary healthcare.
- Targeting available Ryan White CARE Act resources to underserved communities, uninsured and underinsured people disproportionately impacted by HIV/AIDS.
- Partnering with other Ryan White grantees in the state, especially Part D, to promote utilization of HRSA funded health care services by underserved maternal and child populations, including children with special health care needs.

Objective 2.2: The state will increase the utilization of preventive health care and co-morbid disease management, particularly among underserved, vulnerable and special needs populations by:

- Partnering with the HIV Prevention and other state health programs in enabling and increasing participation of eligible individuals in preventive and co-morbid disease management activities (e.g., Hepatitis C screening, prenatal care and health counseling) while accessing HRSA funded programs.

Goal 3: Improve the Quality of Health Care

Objective 3.1: The state will promote effectiveness of health care services by:

- Ensuring HIV health care services meet or exceed accepted quality and accreditation standards.
- Assuring HIV health care service providers appropriately evaluate and coordinate treatment for medical and behavioral co-morbidities.
- Ensuring that HIV health care providers deliver culturally competent care.
- Promoting and supporting performance improvement efforts of Ryan White Part B contractors, providing performance reviews and assistance.

Objective 3.2: The state will promote patient safety and improve patient protections by:

- Maintaining and expanding the quality management program.
- Improving key health status indicators that reflect quality of safety net programs.
- Increasing the awareness of contractors and sub-contractors on issues related to consumer protections, rights and responsibilities, such as the HIPAA Privacy Law.

Objective 3.3: The state will promote access to, and appropriate use of, health care information by:

- Creating and disseminating appropriate health care information in collaboration with family, faith-based and community partners that take into consideration cultural values, linguistic differences, and health literacy.

Objective 3.4: The state will promote the implementation of evidence-based methodologies and best practices by:

- Encouraging the adoption and utilization of appropriate evidence-based clinical practice guidelines by HIV health care service providers.

Goal 4: Eliminate Health Disparities

Objective 4.1: The state will focus resources and services on diseases and conditions with the greatest health disparities by:

- Reducing deaths due to AIDS and other health conditions in populations that are disproportionately affected.

- Reducing the proportion of clients receiving an AIDS diagnosis at the time of their first HIV medical appointment. This will be through outreach, HIV awareness, early HIV testing and referral of positive cases to treatment services.

Objective 4.2: The state will promote outreach efforts to reach populations most affected by health disparities by:

- Establishing outreach/partnering efforts related to raising awareness about major health issues, such as HIV infection and referring those who are HIV positive to treatment.
- Partnering with minority institutions, faith-based and other community-based organizations to help reach diverse populations most affected by health disparities concerning HIV infection.

Objective 4.3: The state will promote the integration of cultural competency into HIV service procedures, policies and practices by:

- Supporting cultural competence training for HIV service providers.

Goal 5: Improve the Public Health and Health Care Systems

Objective 5.1: The state will utilize trend data to assist in targeting program resources toward goals by:

- Allocating HIV funds based on the findings of the most current needs assessment and health care data, including HIV trend data.
- Improving the performance of contractors and subcontractors through performance reviews, analyzing performance trends/issues and providing feedback on the impact of policies on program implementation and performance.

Objective 5.2: The state will increase collaborative efforts to improve the capacity and efficiency of the public health and health care systems by:

- Increasing coordination among public health and private sector organizations to eliminate duplication of services.
- Promoting and supporting cross-program and performance improvement efforts within communities' strategic partnership reviews.
- Maintaining collaboration between other HRSA-funded programs and the Part B grantee (the state).
- Reassessing and, if necessary, eliminating or restructuring services that are not consistent with HRSA's core services.

Objective 5.3: The state will accelerate the development and use of an electronic health information infrastructure by:

- Creating a web-based data entry system that will allow remote data entry as services are provided and will also electronically transmit medical data to the state for reporting and reimbursement.

Goal 6: Enhance the Ability of the Health Care System to Respond to Public Health Emergencies

Objective 6.1: The state will enhance the ability of hospitals, health centers, emergency medical systems, poison control centers, and health professionals to respond to bioterrorism and other public health threats in a timely and effective manner by:

- Continuing to promote and enhance collaboration between state agencies and the private sector in updating and maintaining a response plan to possible public health emergencies. Response to a public health emergency in the state requires swift and coordinated action by all levels of the government. The Delaware Emergency Management Agency (DEMA) is the

lead state agency for coordination of comprehensive emergency preparedness, training, response, recovery and mitigation.

- Develop education and training programs for healthcare professionals to effectively respond to bioterrorism and other public health emergencies.
- Enhance the capability for special needs populations to have access to lifesaving medications, equipment, and medical services during public health emergencies.

Objective 6.2: The state will evaluate the capacity of the health care system to plan for and respond to potentially urgent/emergent health care issues by:

- Developing critical benchmarks to measure system improvement with regard to preparation for bioterrorism and other public health emergencies.
- Assessing training needs of health professionals to respond to bioterrorism and other public health emergencies on a periodic basis.

Goal 7: Achieve Excellence in Management

Objective 7.1: The state will foster and lead a high-quality well-trained workforce by:

- Conducting ongoing workforce planning, including recruitment and retention of key staff, maintaining the state's affirmative action of equal employment opportunities.
- Increasing employee accountability for achieving measurable results through annual performance plans and reviews.
- Supporting cross program teamwork activities to increase efficiency and improve health outcomes.
- Achieving integration of budget and performance information to allow for budget forecasting and maximizing service provision.

Objective 7.2: The state will strategically manage information technology to support the Ryan White Part B program by:

- Enhancing the use of electronic exchange in service delivery billing and record keeping,
- Enhancing the quality and accuracy of data tracked.
- Enabling and improving the integration of HIV-related information in the state.
- Achieving excellence in information technology management practices.

Objective 7.3: The state will preserve the financial integrity of local, federal and state funding by:

- Enhancing financial management and making it more efficient.
- Focusing audit, inspection and other evaluative efforts on ways in which overall program accountability and performance will be strengthened.
- Conducting assessments of state contractors and sub-contractors and providing corrective plan as appropriate.
- Providing timely, useful and reliable budget, accounting and performance data to support decision-making.

Objective 7.4: The state will identify and capitalize on opportunities for cross-program collaboration by:

- Supporting collaborative efforts within the state designed to address crosscutting policy issues.

Specific Priority Recommendations for HIV Core and Related Services

A. Primary Medical Care:

Priority Recommendations:

- Increase the capacity of the HIV service delivery system by recruiting more service providers to ensure appropriate levels of services to underserved and uninsured clients.
- Encourage HIV specialized providers to adhere to current treatment guidelines.
- Incorporate HRSA priorities regarding patient care and access to treatment, eliminating disparities for special populations that access care.
- Encourage clinicians to effectively screen and treat/refer for appropriate treatment of co-morbidities.
- Establish a focused approach to identify and treat HIV infected adolescents.

Guiding Principles:

1. Support the work of the Pennsylvania/MidAtlantic AIDS Education and Training Center as it shares updated information to assist HIV medical care providers in implementing DHHS/IDSA standards of care.
2. Explore the need to assist primary medical care providers in identifying and testing populations at risk, and in turn referring them to specialized HIV treatment centers.
3. Continue to identify the needs of professional caregivers throughout the state and disseminate information of educational opportunities to providers.
4. Increase collaboration between correctional facilities, community based health care clinics, HIV related service organizations and the Division of Public Health to ensure continuous treatment and organized service delivery for incarcerated inmates and those about to be discharged.
5. Continue to make Medicaid applications available to incarcerated persons before their release from correctional facilities, to ensure the continuity of their medical care.
6. Continue to identify HIV-infected pregnant women through routine, voluntary prenatal HIV testing. For women who are HIV infected, refer for appropriate services and treatment (ACTG 076). Title 16, Chapter 12, Section 1204 of the Delaware Code states, "As a routine component of prenatal care, every licensed medical care provider who renders prenatal care…. shall advise every pregnant woman who is his or her patient of the value of testing for HIV infection and shall request of each such pregnant woman informed consent to such testing." (Update: In 2009, the State approved Opt-Out testing for pregnant women.)
7. Providers should be encouraged to retest during the third trimester or at the time of labor and delivery.
8. Based on existing efficacy, continue the support of the HIV/AIDS treatment center established within an existing outpatient drug and alcohol treatment center.
9. Evaluate options for expanding the type of HIV treatment service mentioned above to other outpatient drug and alcohol treatment centers.
10. Continue to identify HIV-infected newborns and refer these families for treatment and services.
11. Encourage providers to refer HIV infected women and their families for evaluation and, if appropriate, enrollment into the Ryan White Part D program which offers a "Family Centered" approach for affected or infected persons with HIV.
12. Enhance the mechanism to identify partners of HIV-infected persons through a partner notification service that is culturally appropriate and is voluntary.
13. Establish a formal process to identify HIV positive adolescents and make appropriate referrals for specialized HIV treatment including referral into Ryan White Part D programs.
14. Enhance adolescent specific HIV care and supportive psychosocial support within existing HIV Treatment Centers.

15. Offer age appropriate counseling of HIV risk assessment/reduction with an STD clinical visit and continue education efforts targeted to the adolescent population related to HIV risk behaviors.
16. Enhance the Medication Adherence program targeting those clients who are at greater risk for non-adherence, especially those who have been on intensive HAART therapy for a long time.

B. Dental Care

Priority Recommendations

- Increase the capacity of the dental care system to provide appropriate care to HIV-infected persons in a timely manner.
- Increase the involvement of dental providers who are knowledgeable about HIV/AIDS.

Guiding Principles

1. Increase the number of providers and funding for routine and emergency dental care for HIV infected clients who meet income criteria.
2. Enhance communication between dental providers, case managers and HIV/AIDS Treatment Centers to coordinate care of the HIV infected client more effectively.
3. Encourage medical care providers to discuss the importance of oral hygiene at routine clinic visits.

C. Mental Health Care

Priority Recommendations

- Increase the effectiveness of mental health programs in providing care to persons dually diagnosed with HIV infection and mental illness, by coordinating referrals and treatment between mental health and HIV medical care providers.
- Develop opportunities for specialized education for HIV service providers to enhance knowledge related to mental health issues.
- Develop opportunities for specialized education in HIV risk assessment, risk reduction and HIV treatment guidelines for mental health providers.
- Encourage mental health treatment programs to incorporate HIV risk assessment screening and referrals for HIV testing into their practice.

Guiding Principles

1. Nearly 40% of clients presenting at HIV clinic sites have mental health disease, which require psychiatric medications that can be prescribed on site. Clients with schizophrenia or are bipolar require polypharmacy, which needs follow up by a psychiatrist. Accessing a psychiatrist in New Castle County is through Pathways but such a service is non-existent to clinic clients in Kent and Sussex Counties. There is a need for more psychiatrists specialized in addiction counseling to look at medications prescribed and ensure that people get the correct medications for their diagnosis.
2. Promote psychiatric training for Advance Practice Nurses due to the current shortage of psychiatrists in Delaware.
3. Promote cross training of staff to reduce the need of client referrals.
4. Evaluate the gap between available inpatient and outpatient treatment and ease of access for dually diagnosed clients in all three counties.
5. Expand health insurance coverage to include counseling for adjustment disorders throughout the course of HIV disease. This coverage will include psychological assessment and testing.
6. Improve access, communication and relationships between the mental health providers and the HIV treatment community. These improved working relationships will allow for better coordination of treatment plans.
7. Work through existing state government to better coordinate the management of dually diagnosed individuals.

8. Enhance the availability of psychiatric care to clients in prisons, on probation or parole.
9. Develop and offer educational opportunities to all levels of HIV Service providers regarding mental health issues and treatment coordination.
10. Develop and offer educational opportunities to mental health providers regarding the incorporation of risk assessment, risk reduction education, and referrals to HIV specialists.
11. Continue to evaluate the need, utilization, and availability of funding for more traditional mental health services, such as bereavement counseling, support groups and peer education.
12. Evaluate the need and provide for additional mental health providers and counselors within the Delaware Correctional System.
13. Continue the support of pre- and post-release case management.

D. Substance Abuse Treatment

Priority Recommendations

- Assist the Division of Substance Abuse and Mental Health to work with the Division of Public Health to implement rapid HIV testing at Methadone Treatment sites and other sites providing substance abuse treatment.
- Increase access to substance abuse treatment for individuals and families living with HIV/AIDS.
- Incorporate HIV risk assessment, risk reduction education, access to HIV testing and counseling, and referral to HIV specialists into substance abuse treatment programs.
- Continue the evaluation of existing models, and expand on models that demonstrate efficacy.

Guiding Principles

1. Sustain the system of referral (linkage) between substance abuse treatment centers, counseling and testing sites, and HIV treatment centers.
2. Develop and offer educational opportunities to medical service providers regarding the identification of active addiction, the referral process for substance abuse evaluation and treatment, the identification of triggers to substance abuse relapse, and early intervention strategies.
3. Support the prison system to continue the provision of substance abuse treatment programs and detoxification units.
4. Support the continuation of the syringe exchange program in Wilmington and explore the possibility of expanding it into the counties.

E. Case Management

Priority Recommendation

- Provide on-going education for case managers, monitor caseloads, and ensure that the medical case management model is being implemented.

Guiding Principles

1. Foster better collaboration between the Division of Public Health, the Medicaid AIDS Waiver Program, the Delaware HIV Consortium (Ryan White Program Part B) and Christiana Care Health System (Ryan White Program Part D) in the operation and evaluation of case management services. This collaboration will promote cohesiveness and consistency of service delivery regardless of the funding source paying for the case management service itself.
2. Enhance operational guidelines and intervention standards for HIV/AIDS case management work.
3. Recognizing that clients may be dually diagnosed with HIV/AIDS, substance abuse issues or mental health issues, develop guidelines that will facilitate the placement of clients with the type of specialized case management service that would best suit their needs.
4. Increase awareness of case management services for persons living with HIV infection.

5. Promote and enhance effective case management services to persons dually diagnosed with HIV infection and other co-morbidities, including mental illness, substance abuse, etc.
6. Develop the global capacity of the case management system to serve the influx of new clients and shifting of existing clients between programs.
7. Increase the number of educational opportunities for case managers to develop job skills and increase knowledge of resources available to their clients.
8. Establish trainings for case managers to deal with the special needs of children, adolescents, and single parent families living with and affected by HIV/AIDS.

F. Other Supportive Services

Priority Recommendation

- Increase the availability of affordable housing for people living with HIV/AIDS.
- Increase consumer and service provider knowledge about existing housing services, and facilitate linkages between appropriate housing-related programs.
- Maintain the network of "wraparound" supportive services as a valuable tool in promoting improved health outcomes for persons living with HIV/AIDS.

Guiding Principles

1. Investigate additional funding sources to expand the capacity of housing programs for persons living with HIV/AIDS, including (but not limited to) long-term rental assistance and short-term rental assistance as homeless clients face great challenges on initiating and/or staying on HAART Therapy.
2. Develop programs that address the needs of low-income persons living with HIV/AIDS in the payment of security deposits for rentals.
3. Develop programs that can provide short-term (30 or 60 days) housing assistance for clients in immediate need, particularly persons leaving correctional institutions, persons recently evicted from their homes, or the homeless.
4. Expand the capacity of existing programs to provide transportation to persons living with HIV/AIDS to meet immediate transportation needs.
5. Evaluate the feasibility of alternate systems and programs (vouchers, car pools, private transportation, etc.) to empower individuals with more private transportation options.
6. Partner with the Department of Transportation and medical care providers to improve the viability of public transportation systems to meet the transportation needs of persons living with HIV/AIDS and other chronic illnesses.
7. Promote consumer involvement in the HIV/AIDS service system to
    a. Enhance the system of trained clinic-based peer educators; and
    b. Develop a system of community-based advocates and mentors.
8. Continue to support Delaware's prison system in offering HIV education and in implementing a peer education programs within each of the prisons.
9. Develop a networking system to link educators with HIV-infected persons willing to share their stories as part of educational presentations.
10. Establish a mechanism by which specialized, episodic one-on-one assistance is offered to persons living with HIV/AIDS who are experiencing difficulty in obtaining services to which they may be eligible.
11. Enhance HIV early intervention outreach programs to specifically targeted populations, as defined by community need.
12. Develop and implement strategies to increase public awareness of HIV/AIDS, the benefits of early detection and treatment, and services available to persons with HIV infection.
13. Promote nutritional counseling and assessment programs that are tailored for persons living with HIV infection and other co-morbidities such as Hepatitis C, hypertension, diabetes, and other associated metabolic disorders.

14. Encourage HIV/AIDS service providers to support the efforts of nutritional counselors in their work with persons living with HIV/AIDS, by reinforcing the importance of such efforts in related services.
15. Support the efforts of volunteer coordination statewide to enhance and expand existing volunteer-based client services, particularly wrap-around programs.
16. Develop a network of trained volunteers and paraprofessionals in the private sector to enhance service delivery.

G. HIV Prevention

Priority Recommendation

- The HIV prevention program has undergone extensive improvement and reformation in the last three years and further major changes in the program before 2009 would be counter-productive, making evaluation of the current program impossible, preventing the development of consistency in services and provider networks, and interfering with quality improvement processes. Care should be given to provide quick and applicable technical assistance, as needed.
- Special effort should be made to secure additional funding sources with sustainability of service as the primary objective. As sufficient funding is obtained to allow implementation of additional services, the Comprehensive HIV Prevention Plan, 2005-2009 should be consulted to ensure additional services address unmet needs.
- Alternative funding sources to supplement the primary CDC HIV prevention program must be secured to maintain and expand services. Primary attention needs to be focused on maintaining and improving current services and secondary attention focused on addressing unmet needs, as funds are available. Specific and consistent attention to evaluation of interventions for outcomes and cost effectiveness must be continued.

Guiding Principle

1. Being able to address a diverse population is important in our society. Because HIV is a disease that does not discriminate, being able to send messages to a diverse population will allow for HIV prevention messages to be heard by those for whom it is intended. National population based studies indicate that youth experiencing feelings of same-sex attraction, engaging in same-sex behavior, or identifying as lesbian, gay or bisexual are at risk for a variety of health and mental health outcomes. It is important to understand that these and many other affects are what these individuals face. Youth engaging in same-sex behaviors without disclosing a same-sex identity to adults may be at risk for a variety of negative health outcomes due to lack of access to developmentally appropriate information, including HIV, STDs and pregnancy.

SECTION II: ANNUAL GOALS AND OBJECTIVES

Goals, objectives, and activities:

- **Short-term (annual) goals and objectives for care and treatment**
  - The Part B program is required to submit the goals and objectives of the program on an annual basis as part of the grant application process. Table 26 describes the current goals and objectives for Delaware's RWCA program.
  - Patients will need and qualify for services described in the table. Funding amounts are identified for Delaware DPH RWCA Part B Program. Future allocation of funding to services will match the priorities identified in this document.
- **Long-term goals and objectives regarding systems, planning, evaluation and service related goals**
  - Appropriate medical care services will be available and accessible to persons at all stages of HIV infection, including those at risk.

- Individuals, families, and communities infected and affected with HIV/AIDS will be provided with accessible HIV support services.
- Individuals and families living with HIV/AIDS will be provided with accessible and appropriate mental health services.
- Individuals and families living with HIV/AIDS will be provided with accessible and appropriate substance abuse treatment services.
- Quality assurance and improvement activities will be conducted for all HIV/AIDS services.

Table 26: Delaware DPH RWCA Program Annual Goals and Objectives

Goal Statement	Objective
Ensure availability of HIV related primary medical care to all uninsured and underinsured HIV infected clients that qualify for ADAP services.	-At least 500 ADAP clinic clients will keep their medical appointments per year.
Ensure access to existing and emerging HIV/AIDS therapies, including new combination antiretroviral therapies and prophylaxis/treatment for opportunistic infections.	-At least 500 clients will receive ADAP medications in a given fiscal year. -At least 20 newly discharged prisoners will receive life-sustaining bridge medications through the ADAP Program. -The Delaware ADAP formulary will include all FDA-approved HIV medications. -At least 250 clinic clients will have access to the HIV medication adherence clinics conducted by a clinical pharmacist.
Maintain Insurance Continuation Program to HIV-infected people in need at the current level.	-In a given fiscal year, at least 14 clients will benefit from the Health Insurance Program funded by ADAP funds.
Ameliorate the growing impact of the HIV/AIDS epidemic among underserved minority and hard-to-reach populations.	-In a given fiscal year, at least 20 just released inmates will benefit from transitional HIV case management: one month prior to and one month following release from prison.
Identify special needs of those impacted by the HIV/AIDS epidemic especially among underserved minority and hard-to-reach populations.	-In a given fiscal year, there will be at least a 10% increase in the number of minority communities accessing at least one Ryan White service. This will be through sustaining HIV outreach and educational activities.
Provide comprehensive outpatient support services for individuals with HIV disease through the Delaware HIV Consortium.	-At least 50 clients will receive transportation to outpatient medical care and/or pharmacies and/or case management in a given fiscal year. -In a given fiscal year, at least 30 clients will receive short-term housing in New Castle county.
Ensure continuation of HIV therapy for ADAP clients on Medicare when Medicare's Prescription Drug Plan (Part D) becomes operational on 1/1/2006.	-All ADAP clients on Medicare will be informed through mail and through their HIV case managers to apply for both the Delaware Prescription Drug Plan (DPAP) and Low Income Subsidy (LIS) through social security. These two programs could assist clients with meeting the True-Out-of-Pocket (TROOP) expenses related to Medicare Part D. -ADAP will provide at least two trainings to HIV case managers and providers on Medicare Part D. -At least 10 clients on Medicare, who do not qualify for Low Income Subsidy (LIS), will have the Medicare monthly premiums paid by the ADAP Program.
Prevent the vertical transmission of HIV disease by using Public Health Service (PHS) Treatment guidelines on all pregnant HIV positive women.	-Chart reviews will be completed with a sampling of maternal and child medical records to verify PHS Treatment guidelines are followed.
Home and community based services will serve the needs of HIV-infected Delawareans. Services that will be provided include home	-At least 10 HIV-infected clients will receive Home and Community Based Services in a given fiscal year.

health nursing, aide care, ambulatory services, durable medical equipment and other home bound support services needed by HIV-infected people in order to function well in their home.	
State Direct Services will serve the needs of HIV-infected Delawareans. State Direct Services include nutritional supplements, direct medical supplies, lab tests, insurance co-pay, ophthalmologic services and dental services.	-In a given fiscal year, at least 400 clients will receive medically necessary dental services. -In a given fiscal year, at least 100 clients will receive laboratory testing, eyeglasses and nutritional supplements. -At least 15 clients will receive outpatient X-ray services, required as a diagnostic procedure for pulmonary tuberculosis.
Develop a quality management system for the RWCA program.	-At least 350 clinic clients will receive at least two CD4 and viral load counts on an annual basis as per the Public Health Service guidelines. -ADAP clients receiving HIV care outside the HIV clinic system will have their clinical charts audited by the HIV Surveillance Program to confirm PHS guidelines are followed.

SECTION III: EVALUATION

Implementation, Monitoring and Evaluation Plans

Implementation will be based on the priority recommendations of the 2008-2010 SCSN and with emphasis on the core services. Generally,

- All services will be culturally sensitive, taking into account clients' ethnicity, race, language, sexual orientation and religious affiliation.
- Agencies will collaborate and where feasible will co-locate services. These programs will assess capacity for the provision of non-traditional service hours. In order for these programs to work, linkages will be made between all types of service providers.
- Service providers will take the initiative to attend trainings that would improve their service delivery. Suggestions for trainings include, but are not limited to, cultural sensitivity, confidentiality, de-stigmatization, and client advocacy. Providers will increase their abilities to educate the community concerning HIV/AIDS.

A. HIV Core Services

1. Primary Medical Care Goals:
   - Increase access to HIV medical care services for all HIV-infected people.
   - Expand the existing medication adherence programs*.

   This service will be monitored by tracking access to Medical Care for all HIV infected clients, including access to the Medication Adherence Clinic and private infectious disease doctors.
   **All patients seen at HIV Wellness Clinic and starting on new HIV medications are given Medication Adherence appointments, tailored to each clients' needs.*

2. HIV Medications
   b. Delaware's AIDS Drug Assistance Program Goals:
      - Increase access to the AIDS Drug Assistance Program for eligible HIV-infected persons.
      - Expand the existing medication adherence programs.

      This service will be monitored by the number of HIV-infected clients receiving clinic ADAP services and financial assistance for the payment of prescription medications. These medications can be part of an HIV Treatment Plan or medications for medical problems exacerbated by HIV/AIDS illness.

c. Health Insurance Program Goals:
- Increase access to the health insurance program to all clients who are eligible and in need.

This service will be monitored by determining the number of clients receiving financial assistance, which helps them maintain continuity of health insurance or to receive medical benefits under a health insurance program, including risk pools.

3. Oral Health Care Goals:
- Identify ways to decrease the length of wait for service.
- Expand availability and access to dental services.

This service will be monitored by tracking the number of HIV-infected clients accessing diagnostic, prophylactic and therapeutic services rendered by dentists, dental hygienists, and similar professional practitioners.

4. Mental Health Services Goals:
- Expand availability of and access to mental health services.
- Improve coordination with HIV service providers and case managers.
- Improve psychiatric services for HIV positive prisoners.
- Improve screening processes of clients to determine need and eligibility for mental health services.

This service will be monitored by identifying the number of HIV-infected clients receiving counseling services provided by a mental-health professional that is licensed or authorized within the state. The number of clients accessing psychiatric medication and spiritual counseling services will be tracked as well.

5. Substance Abuse Services Goals:
- Improve coordination with HIV service providers and case managers.

This service will be monitored by tracking the number of HIV infected clients that receive treatment and/or counseling to address substance-abuse issues (including alcohol, legal and illegal drugs). These services may be provided in an outpatient or residential health service setting.

6. Case Management Goals:
- Improve linkages with Case Managers from other service areas in order to provide a coordinated care system for clients.
- Increase cultural sensitivity to a diversified clientele.
- Increase access to case management services for the incarcerated and those newly released from prison.

This service will be monitored by tracking the number of case managers and social workers that help coordinate medical care, psychosocial and other services to increase independence and self-sufficiency.

B. Other Services

1. HIV Prevention Goals:
- Improve Health Education and Risk Reduction, HIV Counseling & Testing Services, Comprehensive Risk Counseling and Services, Outreach, Referral, Partner Services and other factors as assigned by CDC.

The HIV Prevention program will monitor the services by using CDC mandated data variables in the context of the External Prevention Evaluation and Monitoring web-based reporting system. DPH will also conduct continuous contract management and regular site visits for contracted

providers. It will also coordinate and monitor services between various cooperative programs, such as Family Planning, STD, TB, HIV Wellness and the DPH Laboratory.

2. Early Intervention Programs Goals:
   - Ensure that early intervention programs target HIV-infected people who are unaware of their status, who know their status but are not in care, as well as persons who have been in the system and have dropped out.
   - Encourage collaboration between early intervention programs, prevention programs, and treatment programs.

   This service will be monitored by assessing targeted community work to reach out to persons with HIV or at risk for HIV disease but who may be unaware of the availability or benefits of early treatment for the purpose of facilitating access to HIV-related health services.

3. Eye Care Services Goals:
   - Maintain service levels to ensure that all clients who are eligible and in need are able to access this service.

   The service will be tracked by the number of payments made for medically necessary eye exams and eyeglasses.

4. Housing Goals:
   - Improve linkages with mainstream housing programs in order to help transition to long-term housing assistance programs (such as Section 8).
   - Expand housing services particularly for women with families, substance users, persons with mental health needs, and persons newly released from prison.

   The program will be monitored by tracking the number of persons living with HIV/AIDS who make the transition.

5. Emergency Financial Assistance (EFA) Goals:
   - Seek increased funding for EFA.
   - Develop linkages to and referral mechanisms for community programs that provide financial assistance.
   - Evaluate mechanisms for improving the utilization of EFA dollars in order to serve a greater number of unduplicated clients.

   The service will be tracked by identifying the number of clients receiving assistance with rent, utilities, and emergency shelter on an episodic basis.

6. Food Services Goals:
   - Maintain service levels to ensure that all clients who are eligible and in need are able to access this service.
   - Increase referrals to existing community food programs.

   The service will be tracked using the numbers of HIV-infected clients accessing brown bag programs, emergency food closets, and residential meal programs.

7. Transportation Goals:
   - Ensure programs provide equal access for all populations and service areas, including access to targeted populations such as African Americans, Hispanics, Kent County and City of Wilmington Residents, and Substance Users.
   - Improve accommodations for clients traveling with children.

   Monitoring of the service will include identifying the number of HIV infected clients that use HIV-related conveyance services to access primary medical care or psychosocial support services.

8. Nutritional Counseling Goal:
   - Enhance nutritional education programming to include group and one-on-one clinical counseling.

   This service will be monitored by tracking the number of HIV-infected clients that access nutritional education and counseling to promote good nutrition.

SECTION IV: 2008 CPG MEMBERSHIP SURVEY

In February 2009, the 2008 CPG Membership Survey was conducted. The survey is designed to gain input from community planning groups (CPG) on their perspectives regarding the implementation and quality of the community planning process within their jurisdictions. Its purpose is to provide the CDC and HRSA with a picture of what is occurring in HIV Prevention Community Planning across the country and to serve as a useful tool for planning groups in improving community planning processes at the local level. The opinions of planning group members are very important for both purposes. Input guides improvements to the community planning process nationwide as well as identifies unique strengths and potential training needs within a community.

Of the Planning Council voting membership, 21 of 27 members responded. Overall, the 2008 survey responses were positive, with a 2008 target level of agreement of 90% compared to an actual agreement level of 90%. Responses to the individual objective are as follows, comparing 2007 with 2008:

	Objective	Percentage of Agreement
A	Implement an open recruitment process (outreach, nominations, and selection) for CPG membership.	2008 95% agreed 2007 96% agreed
B	Ensure that CPG membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction and includes key professional expertise and representation from key governmental and non-governmental agencies.	2008 92% agreed 2007 90% agreed
C	Foster a community planning process that encourages inclusion and parity among community planning members.	2008 94% agreed 2007 86% agreed
D	Carry out logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.	2008 94% agreed 2007 96% agreed
E	Ensure that priority target populations are based on an epidemiologic profile and a community services assessment.	2008 93% agreed 2007 94% agreed
F	Ensure that prevention activities for identified priority populations are based on behavioral and social science, outcome effectiveness and/or have been adequately tested with intended consumers for culture appropriateness, relevance, and acceptability.	2008 79% agreed 2007 92% agreed
G/H	Demonstrate a direct relationship between the comprehensive HIV prevention plan and the health department application for federal HIV prevention funding and funded interventions/services delivered.	2008 100% agreed 2007 97% agreed

The following comments were included on the surveys:

- The requirements for co-chairs sometimes inhibits the timely filling of slots. Need more PWA representation.
- Orientations should include not only information but practice tools. Keep educating members regarding the CPG process.
- Membership Committee needs to meet more to be active in filling membership gaps.
- Streamlining the process has lessoned the effectiveness of the council by taking away opportunities for thorough input and discussion and replacing it with quick approvals of presentations.
- SCSN was well developed and included community members.

SOURCES

Delaware Comprehensive HIV Prevention Plan 2005-2009.

Delaware Division of Public Health (2003) *2003-2005 Comprehensive HIV Treatment Plan*. Unpublished report

Delaware Division of Public Health (2006) *2006-2008 Statewide Coordinated Statement of Need & Comprehensive HIV Treatment Plan.* Dover. Graphics & Printing

Delaware Division of Public Health 2008 Epidemiological Profile. Dover. Graphics & Printing

1. United States Census Bureau from website: http://quickfacts.census.gov/qfd/
2. Delaware Division of Public Health, Health Statistics Center, *Delaware Vital Statistics Annual Report 2004*
3. HIV/AIDS Reporting System (HARS), HIV/AIDS Surveillance, DPH
4. Center for Disease Control and Prevention, *HIV/AIDS Surveillance Report 2005* Year-end edition Volume 17, U.S. HIV and AIDS cases reported through December 2005, http://www.cdc.gov/hivdhap.htm
5. Division of Public Health, Disease Prevention and Control, HIV/STD/Hepatitis C Section, HIV Counseling and Testing Annual Report 2005, internal document
6. Division of Public Health, Disease Prevention and Control, HIV/STD/Hepatitis C Section, *Sexually Transmitted Disease Annual Report 2005*, internal document
7. Department of Education, Division of Adolescent and School Health, Youth Risk Behavior Survey (YRBS), 2005 from website: http://www.cdc.gov/nccdphp/dash/yrbs/results.htm
8. Health Resource and Services Administration (HRSA), Ryan White CARE Act Data Reports (CADR) 2005 and 2006.

Delaware HIV Consortium Planning Council Resource Documents

2006-2008 Resource Guide
2006 Agency Capacity and Capability Survey
2006 Consumer Survey
2008 Provider Perspective Survey
2008 Prevention/At-Risk Survey
2008 Gaps Analysis